ASSIGNMENT OF BENEFITS

In consideration of Restoration Chiropractic (hereinafter called "Provider") waiving prepayment of the fees for its services, the undersigned hereby assigns to Provider the undersigned's right to make claim for any benefits to which the undersigned is entitled under any policy of insurance providing Medical Payments Coverage and/or Personal Injury Protection. The assignment is limited to the exact amount of all reasonable charges for necessary treatment delivered to the undersigned or anyone for whom the undersigned is responsible and is covered under such policy. A copy of this assignment is as effective as the original.

The undersigned understands that this assignment empowers the Provider to prosecute a claim in the undersigned's name or in the name of the Provider and Provider may compromise, settle, commence an action or otherwise resolve such claim as in Provider's discretion it deems fit.

The undersigned understands this assignment does not relieve the undersigned from responsibility and liability for payment of such reasonable charges until such charges are recovered from an insurance company. If there is no recovery or partial recovery of payment for such charges the undersigned remains liable for the amount not paid.

The undersigned understands and agrees that Provider may demand full payment at any time after delivery of necessary treatment at a reasonable cost and the time of demand is at the sole discretion of Provider. Provider agrees to wait a reasonable time for the insurance company to pay said charges before demand will be made. The undersigned understands and agrees that the undersigned shall be liable for all collection costs if the undersigned does not pay upon demand and such costs may include, but are not limited to, costs of suit, attorney's fees, interest as allowed by law and such other expenses as are necessarily incurred in collection.

It is understood and agreed between the parties that, as necessary, Provider may prepare and submit complete chiropractic reports, consultations, depositions and court appearances on the undersigned's behalf. The undersigned hereby grants a limited power of attorney to Provider to sign any instrument of payment which the undersigned's name appears as a payee if the instrument is issued in payment of any unpaid charges due Provider for which the undersigned is liable. Provider agrees to promptly refund any overpayment to the undersigned. If is agreed Provider may send such records to the insurance company, attorney or other party as is necessary to effect payment.

______________________________ ______________________________

Date Patient or Guardian

Automobile Accident History

Date: ______________
Patient # ____________

Last ______________________ First __________________ Middle Initial _____ Birth Date __________ Age _____

Address ________________________________ City __________________ ST______ Zip ____________

Phone (H) ______________________ (W) _________________________ (C) _______________________

Email ____

Who may we thank for referring you to our office? ____________________ ☐Friend/Coworker ☐Advertisement ☐Google ☐Yelp

Who is your primary care physician? __________________________ Address: ___________________________

Phone: __________________ Date of last physical/exam? ____________ With Whom? _____________________

Date of Accident: _______________ Time of Accident: _________ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other ___________________________

Was the accident on the job? ☐yes ☐no Where you in a company vehicle? ☐yes ☐no Where were you seated in the vehicle?

☐Driver ☐Passenger ☐Rear-seat ☐Other __________________________________

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐yes ☐no Did you experience a flash of light or explosion in your head? ☐yes ☐no

Did the police come to the accident scene? ☐yes ☐no Is there a police report☐yes ☐no

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Did you go to the hospital? ☐yes ☐no When? ☐Immediately ☐___hours later ☐___days later Which hospital? ______________

How did you get to the hospital? __________________________ How long did you stay in the hospital? ____________

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)_____________________________

What areas were x-rayed? __________________________What was their diagnosis? _________________________

What did they recommend for follow-up care? ____

Was any other doctor consulted after your accident? ☐yes ☐no If yes, please complete information below.

Dr. ________________________ Specialty?______________________ Date first seen:______________

Type of treatment:____________________ Treatment frequency:___________ How long did you treat?_______

Dr. ________________________ Specialty?______________________ Date first seen:______________

Type of treatment:____________________ Treatment frequency:___________ How long did you treat?_______

Were you wearing a seatbelt? ☐yes ☐no If yes, did you receive any injury or bruise from the seat belt? ☐yes ☐no

Did your head hit the head rest during the accident? ☐yes ☐no If adjustable, was the position of the head rest altered? ☐yes ☐no

Was the seat adjustment altered by the accident? ☐yes ☐no Was the seat broken by the accident? ☐yes ☐no

Did the air-bag deploy? ☐yes ☐no If yes, did it strike you? ☐yes ☐no If yes, where? ____________________________

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left

Where were your hands? ☐ One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐yes ☐no If so, were they still on after the accident? ☐yes ☐no

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

Body Part:____

Date symptom first appeared: ____________________

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? ______________________________

What makes symptom decrease?______________________________

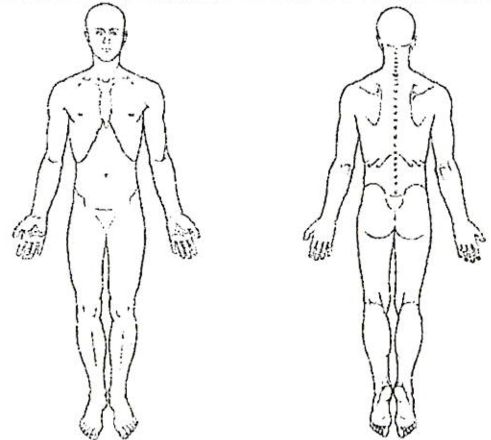
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other__________

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0◊◊◊1◊◊◊2◊◊◊3◊◊◊4◊◊◊5◊◊◊6◊◊◊7◊◊◊8◊◊◊9◊◊◊10

Where does pain radiate to? ______________________________

Please mark areas of pain on the figures below



Do you smoke? ☐yes ☐no If yes, how many packs per week?______ **Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? ______________

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? ______________

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ______________________________

Do you have a high stress level? ☐yes ☐no If yes, list reasons:______________________________

OCCUPATIONAL INFORMATION

Job Involves: ☐Sitting ☐Standing **How long?** _______ ☐Lifting **How much?** _______ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐yes ☐no **If yes, how many days?** ______ **Dates:** ______________

Are your work activities restricted as a result of this accident? ☐yes ☐no **If yes, please explain.**______________________________

Do any of your work activities aggravate your present main complaints? ☐yes ☐no **If yes, please explain.** ______________________________

____

Please list any medications or vitamins you are currently taking (including dosage).

______________________ **Frequency:**__________ **Dosage:** __________ **What is this for?** ______________

______________________ **Frequency:**__________ **Dosage:** __________ **What is this for?** ______________

______________________ **Frequency:**__________ **Dosage:** __________ **What is this for?** ______________

______________________ **Frequency:**__________ **Dosage:** __________ **What is this for?** ______________

YOUR CAR

List the year, make and model of the car you were in: YEAR: __________ MAKE: ________________ MODEL: ________________

Was your car stopped at the time of impact? ☐yes ☐no I If no, estimate the speed of the vehicle you were in: __________mph

I f your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: __________ MAKE: ________________ MODEL: ________________

Was the other car moving at the time of impact? ☐yes ☐no If yes, what was the approximate speed of the vehicle : __________mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

____

____

____

____

____

____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: ______________________ Name of their auto insurance: ______________

Policy #: ______________________ Claim #: ______________________

Auto insurance phone #: ______________________ Name of insurance adjuster: ______________

Driver of the other vehicle: ______________________ Name of their auto insurance: ______________

Policy #: ______________________ Claim#: ______________________

Auto insurance phone #: ______________________ Name of insurance adjuster: ______________

Have you retained an attorney? ☐yes ☐no Name: ______________________ Phone #: ______________

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: ______________

Do you still have any of those symptoms? ☐yes ☐no If yes, which ones? ______________________

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at Restoration Chiropractic/ScoliosisKC and whom ever they designate as assistants to administer care to child.

Name of Child/Minor (please print)____

Name of Parent/Guardian (please print)____

Parent/Guardian Signature_______________________________ **Date:** ____________

Insurance Payments:

We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payment of services regardless of the amount your insurance pays. In other words, if for some reason your insurance company withholds payment, you are responsible for your balance due. ***We base your financial contribution on the benefits quoted to us from your insurance company. There are times when we are misquoted benefits. It is your responsibility to understand your own coverage and any portions for which you may be responsible.

Patient's Signature: ___________________________________ Date:__________

Assignment of Payment:

My attorney and/or insurance carrier are hereby requested to pay direct to Restoration Chiropractic/ScoliosisKC any monies due on account, the same to be deducted from any settlement made on my behalf. It is further understood that I, the undersigned agree to pay Restoration Chiropractic/ScoliosisKC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's Signature: ___________________________________ Date:__________

Printed Name: ___________________________________

Witness: ___________________________________

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Patient's Signature: ___________________________________ Date:__________

INFORMED CONSENT:

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Restoration Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care. I also consent to having my x-rays used anonymously for patient education and teaching needs.

______________________ ______________ ☐

Patient or Authorized Person's Signature   Date   Witness Initials

REGARDING: X-rays/Imaging studies:

<u>FEMALES ONLY</u> → Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____ - ____ - ____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I AM NOT PREGNANT.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

______________________ ______________ ☐

Patient or Authorized Person's Signature   Date   Witness Initials

NOTICE OF PRIVACY PRACTICES

Restoration Chiropractic
503 Main St.
Belton, MO 64012
(816) 425-5578

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice of Privacy describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.
Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.
Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost–management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

KMC University 2012

YOUR HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs–based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the equest. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years; • disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.
Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.
Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.
Signature: ______________________ Date ______________________ Print Name: ______________________