APPLICATION FOR CARE AT LIFE FAMILY CHIROPRACTIC

Today's Date:_____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ ☐ Male ☐ Female

Address: _____ City:_____State:_____Zip: _____

E-mail Address: _____ Mobile Phone:_____ Phone Provider:_____

Text Reminders: ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married Number of children and ages: _____

Social Security # for VA or Insurance Purposes only: _____

Employer: _____ Occupation: _____

Name & Number of Emergency Contact:_____Relationship: _____

Do you have Insurance: ☐ Yes ☐ No Insurance Name:_____

Insurance Card Holder's Name:_____Card Holder's Date of Birth: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

On a scale of **1** to **10** (**10** being the worst pain and **zero** being no pain), rate your above complaints by ***circling the number*:**

Primary: _____	**Primary** or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second: _____	**Second** complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third: _____	**Third** complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth: _____	**Fourth** complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?_____ When is the problem at its worst? ☐ AM ☐ mid-day ☐ late day ☐ PM

How long does it last? ☐ Constant **OR** ☐ On and off **OR** ☐ Random **OR** ☐ Recurring

How did the injury happen? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Have you seen a chiropractor before? ☐ Yes ☐ No **If yes,** when was your last adjustment? _____

Previous chiropractor's name? _____ How long were you under care? _____ What were the results? _____

Have you seen any of the following for your current conditions? ☐ Physical Therapy ☐ Primary Care ☐ Other _____

Name of Primary Care Physician:_____☐ N/A

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
Draw any lines of radiation with arrows if necessary.

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness

S = Sharp/**S**tabbing **T = T**ingling

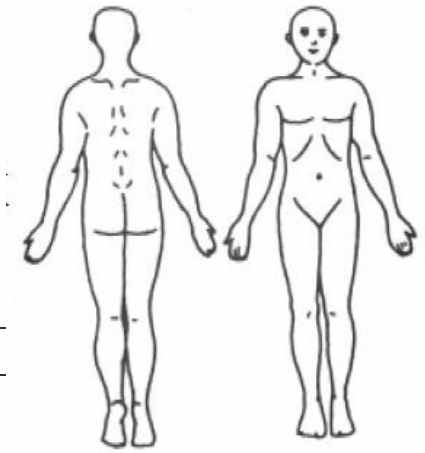
What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Please identify any prescription and non-prescription drugs you are taking: _____

_____

Has there been any recent X-Ray/MRI/Imaging within the last 2 years? ☐ Yes ☐ No



ACTIVITIES OF LIFE

Please identify what current conditions are affecting your ability to carry out activities that are routinely part of your life:

Exercise: ☐ Walking ☐Running ☐ Lifting ☐ Stretching

Self- Care: ☐ Washing/Bathing ☐ Dressing ☐ Shaving

House Chores: ☐ Yard Work ☐ Sweeping/Vacuuming ☐ Dishes ☐ Laundry

Daily Activities: ☐ Driving ☐ Sitting ☐ Standing ☐ Pet Care ☐ Stairs ☐ Sit to Stand ☐ Sleeping

☐ Lifting child/groceries ☐ Looking over shoulder ☐ Computer Use ☐ Machinery Use

☐ Reading/Concentrating ☐ Other _____

Medical History

	Self	Mom	Dad		Self	Mom	Dad
ADD/ADHD	☐	☐	☐	Heart Disease	☐	☐	☐
Alcohol Addictions	☐	☐	☐	Hemorrhoids	☐	☐	☐
Allergies	☐	☐	☐	Hepatitis (A,B,C)	☐	☐	☐
Asthma	☐	☐	☐	HIV/AIDS	☐	☐	☐
Arthritis - Type_____	☐	☐	☐	Immune System - Weak	☐	☐	☐
Bed Wetting	☐	☐	☐	Jaw Pain/TMJ	☐	☐	☐
Blood Pressure	☐	☐	☐	Kidney Problems	☐	☐	☐
Cancer -Type_____	☐	☐	☐	Learning Disability	☐	☐	☐
Cholesterol - High	☐	☐	☐	Liver Trouble	☐	☐	☐
Chronic Fatigue	☐	☐	☐	Lung Disease	☐	☐	☐
Convulsions/Epilepsy	☐	☐	☐	Mental Illness	☐	☐	☐
Depression	☐	☐	☐	Menopausal Problems	☐	☐	☐
Diabetes	☐	☐	☐	Menstrual Pain/PMS	☐	☐	☐
Digestive Problems	☐	☐	☐	Numbness/Tingling	☐	☐	☐
Difficulty Breathing	☐	☐	☐	Osteoporosis	☐	☐	☐
Dizziness	☐	☐	☐	Pain with cough/sneeze	☐	☐	☐
Double/Blurred Vision	☐	☐	☐	Prostate Problems	☐	☐	☐
Drug Addictions	☐	☐	☐	Ringing in Ears	☐	☐	☐
Eating Disorder	☐	☐	☐	Scoliosis	☐	☐	☐
Eye Condition	☐	☐	☐	Seizures	☐	☐	☐
Fainting	☐	☐	☐	Shingles	☐	☐	☐
Fibromyalgia	☐	☐	☐	Sinus/Drainage Problems	☐	☐	☐
Frequent Cold/Flus	☐	☐	☐	Skin Disorder	☐	☐	☐
Gall Bladder Problems	☐	☐	☐	Sleep Disorder	☐	☐	☐
Gastric/Reflux/Ulcer	☐	☐	☐	Stroke	☐	☐	☐
Headaches/Migraines	☐	☐	☐	Thyroid Disease	☐	☐	☐
Hearing Loss	☐	☐	☐	Tremors	☐	☐	☐
				Other _____	☐	☐	☐

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECIEVED
INJURIES →		
SURGERIES →		
CHILDHOOD DIAGNOSIS →		
ADULT DIAGNOSIS →		

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

What is your current goal you want to achieve here at Life Family Chiropractic?

Whom may we thank for referring you to this office?

_____

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 risk is 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 Life Family 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.

_____/____/____ *LFC staff Initials*

Patient or Authorized Person's Signature Date

Cancellation/No-Show Appointment Policy

Our goal is to provide quality health care to all our patients in a timely manner. **No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well.** Please be aware of our policy regarding missed appointments.

Late Arrival

If a patient is more than 10 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comes as best as possible, but we cannot compromise on the quality and timely care provided to our other patients.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of everyone's time, please call Life Family Chiropractic as soon as you know you will not be able to make your appointment. Odds are, there is a very good chance someone else needs it.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to immediate care. Please text or call us at 913-225-9313 between the hours of 9:00 AM – 6:00 PM. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 30 minutes before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, a fee will be accessed to your ledger ranging from $25-45 depending on frequency. These fees must be paid before your next visit.

For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee. This is due to the length of the visit and the ongoing waitlist for new patients. New patients are required to pay prior to scheduling another examination slot.

We understand that special unavoidable circumstances arise in which you must cancel your appointment within 24 hours. We are on your side and do understand these situations.

I hereby authorize payment to be made directly to Life Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Life Family Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME:_____ HR#:_____ Date: _____

LIFE FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Kristen Simpson, DC at (913)-225-9313. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials:_____

LIFE FAMILY CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I understand I can receive a copy of Life Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#

Patient's Signature	Date

LFC Staff	Date