Healing Arts Center

OFFICE USE ONLY:
GI MC PI Cash
Doctor:
_____
Insurance:
_____

NEW PATIENT INFORMATION

Today's Date:_____

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

Address:_____City:_____State:_____Zip: _____

Home#: _____ Cell#: _____ Work#:_____

Email: _____

By checking this box, I consent to receiving appointment reminders: (check one) □ YES □ NO

Date of Birth: _____/_____/_____ Age: _____ Gender (circle one): Male Female SSN: _____-_____ -_____

Marital Status (circle one): M S D W Height: _____ Weight: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Care Physician: _____ May we contact, if necessary? (Please Circle) Yes No

How did you hear about us? Patient: _____ Doctor: _____

Staff Member: _____□ Drove-by/Walk-in □ Insurance □ Internet □Other_____

Please list medications and/or supplements you are currently taking and why:

Medication/Supplement	Dosage/Frequency	Medication Purpose	Medication/Supplement	Dosage/Frequency	Medication Purpose

Please list if you have any allergies (food, medication, seasonal, such as pollen etc.):_____

_____

(913) 894-4428 (Office) | (913) 894-4427 (Fax) | 15545 W 87th St, Lenexa, KS 66219 | lenexachiroprators.com

Today's Date:_____

Patient Name:_____ Date of Birth:_____

PRESENT CONDITION ASSESSMENT

List conditions in order of concern	Pain Scale	Date of Onset
1.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
2.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
3.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
4.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
5.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	

Are any of the above condition(s) related to:

□ Sports Injury
□ Auto Accident
□ Job Related
□ Other

Who have you seen for this condition?

□ Chiropractor
□ Medical Doctor
□ Physical Therapist
□ Other

When did your symptoms begin? (Please provide approximate date):_____

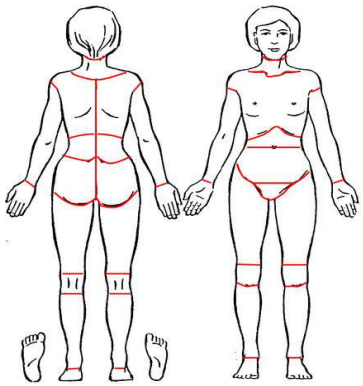
Have any of the above conditions changed since onset? (Please circle) Yes No **If so, please indicate which ones:** _____

_____

What makes the pain better? _____

What makes the pain worse? _____

Please indicate on the figures where you have any of the following using the scale below:



A =Ache
SF =Stiffness
SH =Sharp
S =Soreness
N =Numbness
P =Pain
C =Constant
XX =Other

Please check if you are currently experiencing any of the following symptoms:

□ Allergies	□ Headaches	□ Muscle Spasms	□ Tingling in Arms
□ Arm Pain	□ Indigestion	□ Neck Pain	□ Tingling in Legs
□ Breathing Troubles	□ Joint Swelling/Pain	□ Numbness in Fingers	□ Toe Numbness
□ Circulatory Problems	□ Knee Pain	□ Pregnancy	□ Vomiting
□ Constipation	□ Leg Cramps	□ Ringing in Ears	□ Weakness in Legs
□ Dizziness	□ Loss of Smell/Taste	□ Shoulder Pain	□ Other
□ Fatigue	□ Low Back Pain	□ Sinus Problems	□
□ Fever	□ Mid Back Pain	□ Sleep Problems	□

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Today's Date:_____

Patient Name:_____ Date of Birth:_____

Walking	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Pushing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Reading	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Gardening	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dancing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Shoveling	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Rolling Over	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Watching T.V.	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Playing Sports	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting to Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sexual Activity	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Bending	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Climbing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Concentrating	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Recreation	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform

Please identify how any of your current conditions is affecting your ability to carry out activities that may be routinely part of your life.

Do you consume any of the following? Please indicate approximate amount

Water	Yes No	Amount _____	Alcohol	Yes No	Amount _____
Soda	Yes No	Amount _____	Smoke	Yes No	Amount _____
Caffeine	Yes No	Amount _____	Exercise	Yes No	Amount _____

Have you ever undergone any surgeries? (Please circle) Yes No If so, please indicate which surgeries were performed and when :

_____

_____

_____

MEDICAL HISTORY

	Self	Sibling	Mom	Dad		Self	Sibling	Mom	Dad
ADD/ADHD					Depression				
Arthritis					Diabetes				
Blood Pressure					Headaches				
Cancer					Heart Disease				
High Cholesterol					Varicose Veins				
Chronic Fatigue					Weight Gain/Loss				
Convulsion					Stroke				

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Today's Date:_____

Patient Name:_____ Date of Birth:_____

Informed Consent

PATIENT NAME: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The Doctor may use that procedure to treat you. The Doctor may use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
Spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, ultrasound, hot/cold therapy, electrical muscle stimulation, and/or radiographic studies (x-rays)

The material risks inherent in chiropractic treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray (if applicable). Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include:
Self-administered, over-the-counter analgesics and rest
Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
Hospitalization
Surgery
If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

Signature of Parent or Guardian (if patient is a minor): _____

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HEALING ARTS CENTER OF LENEXA

FINANCIAL POLICY

Last Revised 8/15/2020

It is the policy of Healing Arts Center to provide our patients with access to the highest quality services and products available. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

INSURANCE PARTICIPATION STATUS

While our providers are in network with a large number of insurance carriers, they are not in-network with all insurance carriers. Network participation status can sometimes vary from provider to provider within the practice. If you have questions regarding whether or not your provider is in network with your insurance plan, please contact our office.

INSURANCE PRIOR AUTHORIZATION AND REFERRALS FROM PRIMARY CARE PROVIDERS

Some require a referral from a primary care provider in order to be seen by a specialist. Some insurance plans require prior authorization from the insurance carrier before we may treat you. This is important because if the referral or prior authorization has not been received, your insurance carrier may not provide coverage for your visit. If your insurance plan requires a referral and/or prior authorization, it is your responsibility to obtain the referral and/or pre-authorization before your first visit. If we have not received your referral and/or prior authorization, we will ask that you reschedule your appointment.

SUBMISSION OF INSURANCE CLAIMS AND INSURANCE POLICY COVERAGE

If you provide us with your current insurance information, we will submit your claim to your insurance carrier for services rendered during your visit. Please understand that the health insurance policy that you select is a contract between you and your insurance carrier. You are financially responsible for all charges that are not paid by your insurance carrier. Wherever possible, we can work together with you to help you understand your insurance benefits, but ultimately you as the patient are responsible for understanding your policy benefits and limitations. If you have specific questions regarding your insurance policy coverage that our office cannot answer, please contact your insurance carrier directly using the customer service number on the back of your insurance card prior to your visit.

PAYMENT AT TIME SERVICE

We require all patients to provide payment for services rendered on the day of your visit. For patients utilizing insurance benefits, this payment includes any applicable copayment, co-insurance, or deductible for covered services and payment
in full for any non-covered services. Insurance carriers refer to this cost as “patient responsibility.” For self-pay patients,
we require payment for the full cost of services rendered during your visit.

PAYMENT OPTIONS

You will receive paper statements by mail if you have an account balance. Your financial obligation will be clearly listed
in the area marked “Please Pay.” It is due and payable upon receipt. For your convenience, we accept payment in the
form of cash, check, Visa, MasterCard, American Express, and Discover. Payments may be called in at (913) 894-4428, or mailed to 15545 West 87th Street, Lenexa, Kansas 66219. If you are submitting payment by mail, please cut and include the applicable portion of the statement with your payment so that our office can post your payment to the proper patient account.

OUTSTANDING BALANCES REFERRED TO COLLECTIONS

We urge you to keep your account current. If your account balance becomes more than 90 days past due, it will be referred to collections. You will then need to contact the collections company directly to pay your outstanding balance. If you need to make special payment arrangements due to an unforeseen circumstance, it is your responsibility to contact our billing manager before your account is turned over to collections. We reserve the right to discharge that patient from the practice.

- $50.00 New Patient Exam/Functional Medicine Office Visit/Consultation/Physical Exam
- $25.00 Adjustment/Treatment

NO-SHOW FEE

Appointments cancelled without 24 hours' notice will be assessed a no-show fee.

_____ _____ _____

Patient Full Name Patient Signature Date

Healing Arts Center of Lenexa

15545 W 87th St., Lenexa, KS 66219 ♦ Phone (913) 894-4428 Fax (913) 894-4427

Last revised *08/13/2018*

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- HIV/AIDS-related information*
- Communicable disease information*
- Genetic information*
- Sexually transmitted diseases and reproductive health information*

*unless otherwise required by law

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

You may contact the privacy officer with questions via phone at (913) 894-4428, or by mail at ATTN: Privacy Officer, Healing Arts Center, 15545 W. 87th St., Lenexa, KS 66219.

My signature below indicates that I have been offered a copy of Healing Arts Center of Lenexa's Model Notice of Privacy Practices.

_____ _____

Patient Full Name (Printed) Patient Signature

_____

Date