File _____ Date _____ Name _____

Above All
Family Chiropractic, LLC

Scott E. Hollis, DC, DABCI, FICPA
Chiropractic Internist ~ Chiropractic Family Practice ~ Chiropractic Pediatrics
1412 SW State Route 7, Suite F ◊ Blue Springs, MO 64014 ◊ 816-228-5433

PATIENT ADMITTANCE FORM

HOW DID YOU HEAR OF OUR WELLNESS CLINIC? _____

Date _____ Legal Name _____ Nickname _____
Address _____ City _____ State ____ Zip _____
Phone (Cell) _____ Phone (H) _____ Phone (W) _____ Ext. _____
Date of Birth _____ Age ____ Sex ____ Email Address _____
Social Security # _____(required) Drivers License # _____ State_____
Spouse's Name _____ Phone _____ Email Address _____
Your Occupation _____ Children (Ages) _____
Your Employer _____ Employer Address _____
Nearest relative not living with you (Emergency Contact) Name _____
Relationship _____ Phone _____ Address _____

INSURANCE INFORMATION

Our fee structure is based as a Cash Fee-For-Service System in which ALL FEES are at or below customary fees in the surrounding area. Our low cost primary health service fees are designed to fit well with any financial budget and our clinic policy to help every person get the care they need without financial barriers. Above All Family Chiropractic, LLC practices as an out-of-network or non-participating clinic regarding insurance claims, however, any payment for services can be submitted by you, the patient, for reimbursement directly to yourself from your insurance company. If you desire to submit claims yourself to an insurance company we will issue you a "Superbill" upon request. If **Finances** are a roadblock to receiving treatment, **Please Ask** to speak with the Staff, as we offer options like AFLAC, Financial Freedom Payment Plans, CareCredit, and Family Plans.

TREATMENT AUTHORIZATION

I hereby authorize this office, the staff and doctors to examine and treat my bodily complaints as the doctors deem appropriate. I give authority for any/all procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment in full for services performed, along with all outside laboratory and/or diagnostic services performed on my behalf, immediately at the time services are rendered before departing the premises, unless other financial arrangements are made in writing and in advance to services being provided. Should collection of unpaid and/or past due service fees become necessary, I accept responsibility to pay for all charges, fees, and associated collection / attorney fees. I, the undersigned, do hereby agree to pay a service fee of $35 per fifteen minute appointment block for any canceled or missed appointment occurring without having given at least twenty four hours advanced notice.

Patient Signature (X) _____ Date _____

CONSENT TO TREAT A MINOR

I (we) being the parents, guardian or custodian of _____ age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic tests, X-rays, and any treatment that in their judgment is deemed necessary while said minor is under care of this office's doctors and staff until legal age. All charges for services and care given to said minor will be charged directly to me (us) and I (we) will be personally responsible for payment at time services are rendered.

Parent, Guardian, or Custodian Signature (X) _____ Date _____

MAJOR COMPLAINT

Patient Name: _____ Date: _____ DOB: _____ Age: _____ Sex: _____

What is (are) your major complaint(s) ranked in priority? (Exact Description) _____
_____
_____
_____
_____

Is it related to a Fall or Accident? (Describe) _____
How long have you had this condition? _____
Have you had similar conditions in the past? _____ When? _____ How many times? _____
The condition is (circle): Worse Same Better Consistent Recurring Progressively Worse
How does this condition interfere with your work or daily routine? _____
At what time of the day is the condition worse? (Circle) Upon Awakening Mid-Morning Afternoon Evening Night
What activities make this condition worse? _____
_____
What activities make this condition better? _____
_____
Names of other doctors seen for this condition _____
Name of hospital (if applicable) _____
Previous diagnosis for this condition _____
Type of previous treatment and/or surgery for this condition _____
Duration of previous treatment for this condition _____
Results of previous treatment (circle): Good Fair Poor Other _____
Medications you are presently taking? _____(more space below)
What do you believe is wrong with you? _____
What are you seeking from this office?
□ Relief Care – relief of current symptoms. Underlying structural cause still remains and symptoms may recur in the future.
□ Corrective / Rehabilitative Care – relief of current symptoms AND treatment of the underlying structural causes of this problem to Minimize recurrence of problem in the future.

OTHER COMPLAINTS

What other conditions or problems are you presently being treated for, or are concerned about? _____
_____
Are you also seeking our help for these conditions? _____

PREVIOUS CHIROPRACTIC CARE

Name of Chiropractor _____ Address _____
Condition treated _____ Were X-rays taken? _____
Type of treatment received _____ Results of treatment _____
Date of last visit _____ **Reason for leaving, if any?** _____

PREVIOUS HEALTH PROBLEMS

Circle any of the following you have had OR are presently having:

□ Fractured bones	□ Spinal taps	□ Fainting
□ Dislocation	□ Scoliosis	□ Birth defects
□ Joint replacement	□ Diabetes	□ Osteoporosis
□ Metal screws/implants	□ High blood pressure	□ Cancer
□ Cervical whiplash	□ Stroke	□ Tumor
□ Electronic implant	□ Aneurysm	□ Cyst
□ Pacemaker	□ Convulsions	□ Ear infections
□ Herniated Disc	□ Seizures	□ Birth Complications
□ IBS	□ Memory lapse	□ Asthma
□ Pinched nerve	□ Dizziness	□ Bed wetting
□ Spinal surgery	□ Concussion	□ Heart attack
□ Spinal injections	□ Knocked unconscious	□ Incontinence
□ Warfarin-Cumadin Med	□ Headaches	□ Bowel/Gut Trouble

Are you pregnant? Y N
How many weeks gestation?____
Any past / present illnesses?
_____
_____
_____
Any past Surgeries / Hospitalizations?
_____
_____
_____
Medications / Supplements now taking?
_____
_____
_____

Outline of Procedures for our New Patients

Step One: All new patients are requested to fill out a personal health history & nutritional questionnaire. AAFC is a Primary Care clinic which offers services in a wide variety of natural health care choices.

Step Two: You will have a consultation with the doctor to discuss your specific health problem(s), this will usually last 30-45 minutes. Family members are welcome and encouraged to attend this consultation.

Step Three: Preliminary screening will be performed to help determine whether you have a chiropractic case, or an internal medicine case, or a combination thereof. Dr. Hollis has a limited number of case openings. **If you are not accepted** as a chiropractic or internal medicine patient, we will try to assist you in locating a medical or natural physician or specialist which we feel your condition requires.

Step Four: If preliminary screening indicates that you are a chiropractic or internal medicine case, additional diagnostic examinations such as X-ray, MRI, CT, Laboratory tests, etc., may be required. If so, the necessity and cost will be explained before the procedure is performed.

Step Five: The doctor will review with you the results of your diagnostic examinations, explain their significance, and make the appropriate recommendations for treatment. **Usually your first treatment can begin on the first visit**. Family members are welcome and encouraged to attend this explanation.

Step Six: Treatments may need to begin on your 2nd visit, and will continue until your condition has reached maximum medical improvement. **If** for some reason you do not respond to care, or are Dissatisfied with your progress, **PLEASE bring this to the attention of the doctor** and a different approach to your treatment will be pursued, or you may stop receiving treatment at any time without further financial obligation, except for the services previously rendered or prepaid in advance. No refunds will be given at any time; not for services, supplements, products, nor prepaid unused services. Completion of those services will need to be scheduled and completed.

Step Seven: ***Financial arrangements.*** You are responsible for payment of ALL services at time services are rendered. In some cases, payment will be required before services are rendered, at the clinic's staff discretion. If you have difficulty meeting your financial responsibility for billed charges, our office offers many types of flexible payment arrangements as long as they are made prior to services being rendered. These include in-house, no interest payment plans, a CareCredit account – a no interest external finance corporation, application for hardship assistance, and more are available. We reserve to right to refuse service to anyone at any time!

Step Eight: ***Treatment Plan***. Dr. Hollis prides himself in getting patients feeling better quickly and affordably! He does so by using ***safer and more gentle***, non-invasive methods than other clinics do. Appointments are made in advance to ensure your time and convenience is honored, yet ensuring proper healing and recovery. Appointments are made reserving time **Just For You**, and we appreciate the courtesy of at least a **24-hour Advanced Notice** which is required by office policy if you need to change any appointment. A **Service Fee of $35 per scheduled 15 minute time block** is charged if no 24-hour notice is given, an appointment is missed, or if short notice is given in a non-emergency situation.

I have read, fully understand, and agree to abide by any / all office policies or procedures, including but not limited to those listed above, of this office at all times, which may change without notice at any time, including any new policies that are added at a later time. By signing below I acknowledge that the service fees of this clinic are my legally binding financial responsibility and collection of these fees will be followed as applicable by law.

Printed Patient Name: _____ Date: _____

Patient Signature (X): _____ Date: _____

Staff Witness: _____ Date: _____

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FINANCIAL RESPONSIBILITY

***** I clearly understand that all services rendered me are my responsibility and payment is expected at the time services are rendered, before leaving the premises. *****

Printed Patient's Legal Name: _____

Patient's Legal Signature (X): _____ **Date:** _____

If under 18 years of age, Parent or Guardian's Signature: _____

Informed Consent

Chiropractic is a system of diagnosis and treatment based on the concept that the nervous system coordinates all of the body's functions, and that disease results from a lack of normal nerve function.

Chiropractic employs manipulation and adjustment of body structures, such as the spinal column, so that pressure on nerves coming from the spinal cord due to displacement (subluxation) of a vertebral body may be relieved. Practitioners believe that structural misalignment and nerve pressure can cause problems not only in the local area, but also at some distance from it, including internal organs!!!

Doctors of Chiropractic are primary care physicians in the state of Missouri. However, their treatment is not designed to take the place of any treatments your medical doctor may have recommended.

Doctors of Chiropractic are not licensed to prescribe prescription medication nor advise patients regarding their prescription medication.

At Above All Family Chiropractic, LLC, we feel that nutrition is fundamental to the healing process and to maintain wellness. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment, but is not to be construed as the diagnosis or treatment for any disease of condition, and not to be considered as advice in lieu of recommended medical advice or treatment.

I have read and understand the above:

Patient's Legal Signature (X): _____ **Date:** _____

Witnessed by: _____ **Date:** _____

Above All
Family Chiropractic, LLC

1412 S. 7 Highway, Ste. F Blue Springs, MO 64014 **(816)-228-LIFE (5433)**

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT- ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. A photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and /or licensed professionals of this Facility.

Our Facility and staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use and disclose your PHI for health care delivery purposes. Your PHI may be used and/or without your written authorization by the doctors and staff of this Facility for the purposes of your care and the treatment; paying your health care bill; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated and comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy and physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions and reactions and/or other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against and all insurance benefits, proceeds of any settlement, judgment or verdict which may be party to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I the assignee further authorize any and all insurance company, attorney and any and all third party payer to pay directly to the Facility all sums of money due or may become due, and to withhold such sums from any health and accident workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility and staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility and staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day service are rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlements(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any treatment, products, and services rendered to the patient or minor shown below.
5. A non-discriminator "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a "periodic rate" of 1.5% per month – 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest costs related to but not limited to all collection related expenses, attorney fees, court and filling fees. Returned checks, debit and credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
7. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit and debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms and conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

_____

Print Name of Patient

_____ _____

Signature (if minor, parent must sign) Date