File ____

Date ____

Name ____


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?*** _____

Legal Name _____ Nickname _____ Date _____
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 _____
Occupation _____ Children (Ages) _____
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 health service fees are designed to fit within 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 services and their fees 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 Office Manager, as we offer many options for Financial Payment Plans, Financing, and Hardship Assistance.

## 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 by this office, 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 advance to services being provided. Should collection of past due amount become necessary, I will become responsible for all charges, fees, and attorney fees.

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 advisable 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 the type of physician or specialist which we feel your condition requires.

**Step Four:** If preliminary screening tests indicate that you are a chiropractic case, additional diagnostic examinations such as X-ray, MRI, CT, laboratory test, 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 usually begin on your second visit, and 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.

**Step Seven:** ***Financial arrangements.*** You are responsible for payment of all services at time services are rendered. 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.

**Step Eight:** ***Treatment Plan***. Dr. Hollis prides himself in getting patients feeling better quickly and affordably! He does so by using safe and 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 **24-hour Advanced Notice** which is required if you need to change any appointment. A **Service Fee of $35** is charged if no notice is given, or if short notice is given in a non-emergency situation.

I have read, fully understand, and agree to abide by the above procedures and policies of this office at all times, even if these may change, along with any others, or in the event new policies are added, without my knowledge or consent.

Patient Signature (X): _____ Date _____

Witnessed by: _____ Date _____


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**Patient's Printed Legal Name:** _____

***** 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. *****

**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 misalignment and nerve pressure can cause problems not only in the local area, but also at some distance from it.

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:** _____

***If your injuries could be due to an <u>Automobile Collision</u>, please fill out this page.***

# ACCIDENT PATIENT HISTORY

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

**Date of Collision:_____ Time: _____ Location: _____ □ Dry □ Wet □ Snow/Ice**

Were you: □ Driver □ Passenger □ Front Seat □ Back Seat How many other people inside your car? _____

Were you wearing a seat belt? □ Yes □ No Did airbags deploy? □ Yes □ No Was any car(s) towed away? □ Yes □ No

## DESCRIPTION OF COLLISION:

Were you struck: □ From Behind □ In Front □ Right Front □ Right Middle □ Right Rear

□ Left Front □ Left Middle □ Left Rear □ Side-swiped □ T-boned

Were you: □ Moving □ Stopped □ Turning □Right □ Left Which lane/direction traveling in? □ R □ L / □ N □ S □ E □ W

How many Impacts or Collisions were you in? _____ Collision with any Objects other than vehicles involved? □ Yes □ No

Approximate speed of automobiles at impact: Yours _____ mph Other _____mph Other _____mph

Did you see the accident coming? □ Yes □ No If **<u>YES</u>**, do you remember stiffening for the impact? □ Yes □ No □ Unknown

Which way were you looking at impact? _____ Do you remember stiffening before impact? □ Yes □ No

Upon impact which way was your body thrown? □ Forward □ Backward □ Right □ Left □ Up □ Out

Did you hit your head <u>or</u> any body part on anything? □ Yes □ No What/Where? _____

Lose consciousness? □ Yes □ No How Long? _____ Visible Wounds?: □ Bruising □ Bleeding □ Concussion □ Burns

Type of vehicle you were in? _____ Amount of damage? _____

Type of other vehicle(s)? _____ Amount of damage?_____

Police report filed? □ Yes □ No With what municipality or city? _____

Citation Issued? □ Yes □ No To whom? _____ What violation was cited? _____

## TREATMENT RECEIVED:

When did the pain begin? _____ Pain is? □ Dull □ Sharp □ Numb/Tingling

What does the pain interfere with you doing during your daily routine? _____

Since Collision the pain is?: □ Less □ Same □ Worse Pain Severity? □ Mild □ Moderate □ Severe □ Unbearable

Transported to Hospital? □ Yes □ No By Whom? □ Self □ Other Person □ Ambulance □ Air Ambulance

Which Hospital? _____ What day did you go? □ Same Day □ Next Day □ Other

What treatment did you receive? _____

X-rays Taken? □ Yes □ No What X-rays? _____

Have you seen another doctor of any kind since the MVA? □ Yes □ No

Dr. Name _____ Where _____

What treatment did you receive? _____

Patient Signature (X): _____ Date: _____

Witness Signature: _____ Date: _____