Robertson Chiropractic LLC

1220 S Meridian Avenue Suite B,
Valley Center KS, 67147

New Patient Profile

Today's Date: _____ /_____ /_____ **Patient ID Number:** _____

PATIENT INFORMATION

Name: (*First MI Last*) _____ **Preferred Name:** _____

Address: _____ **City:** _____**State:**_____ **Zip**:_____

Phone (Home): _____ **(Mobile):** _____ **(Work):** _____

Email: _____ _____ **Employer:** _____

Social Security #: _____**Date of Birth:** ___/____/_____ **Gender:** M / F **Marital Status:** Single / Married / Other

Spouses Name: _____ **Spouses Employer:** _____

Student Status: *(If Applicable)* Full Student/ Part Time Student/ Non-Student

If Patient Is Minor/Child: Parent's Employer _____ **Parent's SSN:** _____

Referred By: (Name) _____ *(Please circle one)* Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: (*First MI Last*) _____ **Primary Care Physician:** _____

Phone (Home): _____(Mobile): _____ **Doctor's Phone:** _____

Relationship: Child/ Parent/ Spouse: Other: _____

FINANCIAL INFORMATION

□ Insurance □ Worker's Comp □ Self-Pay (Cash) □ Personal Injury/Auto □ ChiroHealth USA □Other _____

Primary Insurance

Insurance Name:_____ _____

Relation to Insured: Self/Spouse/Parent/Child/Other

Name of Insured (*Policy Holder*): _____

Insured Birthdate _____

Group Number: _____ _____

Policy Number: _____

Secondary Insurance

Insurance Name: _____

Relation to Insured: Self/Spouse/Parent/Child/Other

Name of Insured (*Policy Holder*): _____

Insured Birthdate: _____

Group Number: _____

Policy Number: _____

RESPONSIBLE PARTY

Who is responsible for Payment? (*Circle one*) Self / Other **Relationship to you:** _____

Information About Responsible Payer if Other Than Yourself

Name: (*First, MI, Last*) _____

Address: _____ **City:** _____**State:**_____ _____ **Zip**:_____

Phone: _____ **Email:** _____

ACCIDENT INSURANCE INFORMATION

Name of your Auto Insurance Company: _____**Accident Claim Number:** _____

Agent Name: _____ ___ **Agent Phone Number:** _____

Name of Liable Insurance Company:_____ **Phone Number**:_____

Claim Number _____ _____ ____ **Insured's Name**: _____

Attorney Name _____ ____ **Phone Number:** _____

Auto Accident Date **Time** **(am)(pm)** **Location**

Were you □ Driver □ Passenger

□ Unconscious □ Treated in E.R. (*explain*) _____

□ Wearing a Seatbelt □ Transported by Ambulance

Vehicle Damage □ Minimal – Moderate □ Severe – Totaled **Was the Vehicle Towed away?** □ Yes □ No

Police Report □ Yes (*please name Police Department*) _____ □No

Activities □ No restrictions □ Missed _____ days of work or school

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____ **Claim Number:** _____

Contact Person: _____ **Phone Number:** _____

Date of Injury: _____ **Time:** _____ (am) (pm) **Location:** _____

Describe injury and how it happened: _____

_____

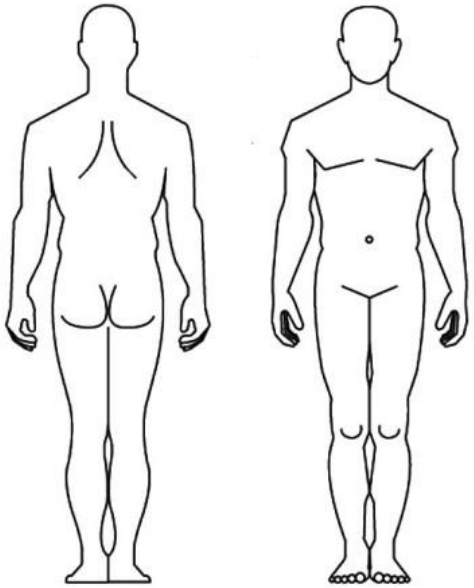
Accident Reported to _____ **on** _____(*date*)

□ **No restrictions** □ **Missed** _____ **days of work or school**

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

_____



Circle location (s) of your symptoms on body drawing. Outline using the symbols for the type of sensation

Pain	. . . . .
Numbness	+ + + + +
Burning	/ / / / /
Ache	x x x x x

Describe WHEN and HOW this began: _____

_____

_____

Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of symptoms: Sharp / Stabbing / Burning /Achy / Dull / Stiff & Sore / Other: _____

How frequent is it? Off & On / Constant

Does this complaint radiate/shoot to any other area of your body? No / Yes (*Describe*) _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / Medication / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

What daily activities are being affected by this condition? (*Describe*) _____

Have you received any other treatment? None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____

Were you helped? Yes / No **If "No", please explain why:** _____

Did you receive any: X-rays / MRI / CT / Other: _____ **When and where?** _____

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Current Medications & Supplements: NONE

Name	Dosage	Frequency	Method

Allergies to Medications: NONE

Name	Reaction

Past Health History:

Please list any surgeries, major injuries, traumas or hospitalizations: _____

_____

Please list any falls in the last 24 months: _____

Is there any possibility you may be pregnant? (*Please circle*) Yes / No.

Family History

Father □ Living - Age: _____ □ Deceased – Cause _____ Mother □ Living - Age: _____□ Deceased – Cause _____

Brother □ Living - Age: _____ □ Deceased – Cause _____ Sister □ Living - Age: _____□ Deceased – Cause _____

Other □ Living - Age: _____ □ Deceased – Cause _____ Other □ Living - Age: _____□ Deceased – Cause _____

Social and Occupational History

Smoking / Tobacco Use: Every day / Some Days / Former / Never

Education: High School / College / Post Grad / Other

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Lifestyle	Describe
Hobbies / Recreation	
Exercise	
Diet	
Work	
Other	

Are you currently experiencing any of these symptoms? (Please check all that apply)
Many of the following conditions may respond to Chiropractic and Acupuncture treatment.

GENERAL:
□ Fever
□ Fatigue
□ Loss of Sleep
□ Thyroid Disease/Goiter
□ Unexplained Weight Loss or Gain
□ None in this category

MUSCULOSKELETAL:
□ Low Back Pain
□ Mid Back Pain
□ Neck Pain
□ Arm Problems _____
□ Leg Problems _____
□ Painful joints
□ Muscle Aches/Soreness/Spasms/Cramps
□ Spinal Curvatures
□ Broken Bones: _____
□ Other: _____
□ None in this category

NEUROLOGICAL
□ Weakness
□ Loss of feeling
□ Numbness or tingling sensations
□ Dizziness or light-headedness
□ Frequent Headaches
□ Convulsions/Seizures
□ Tremors
□ Stroke
□ Previous concussions. How many? ____
□ Other: _____
□ None in this category

GENITOURINARY:
□ Frequent Urination
□ Painful Urination
□ Blood in the Urine
□ Frequent urinary tract infections
□ Kidney Stones
□ Change in force/strain with urination
□ Incontinence or Bed Wetting
□ Sexual difficulty
□ Other: _____
□ None in this category

GASTROINTESTINAL:
□ Loss of Appetite
□ Abdominal Pain
□ Nausea/Vomiting
□ Blood in Stool
□ Diarrhea
□ Constipation
□ Ulcers
□ Jaundice
□ Bloating
□ Hemorrhoids
□ Hernias
□ Other: _____
□ None in this category

CARDIOVASCULAR AND HEART
□ Irregular heart beat
□ High Blood pressure
□ Chest pain
□ Rapid Heartbeat
□ Swelling in hands and feet
□ Other: _____
□ None in this category

RESPIRATORY
□ Difficulty Breathing / Shortness of Breath
□ Chronic Cough
□ Spitting Blood
□ Asthma
□ Other: _____
□ None in this category

EYES, EARS, NOSE, THROAT
□ Wear contacts/glasses
□ Blurred/double vision
□ Eye pain
□ Sinus/allergy trouble
□ Nose pain
□ Ear pain
□ Ringing in the ears
□ Hearing loss
□ Swollen glands in the neck
□ Jaw pain
□ Dental Pain
□ Grind teeth at night
□ Other: _____
□ None in this category

DO YOU EXPERIENCE:
□ Nervousness
□ Depression
□ Confusion
□ Mental Disorder
□ Other: _____
□ None in this category

SKIN AND BREASTS
□ Rash/itching
□ Change in hair or nails
□ Non-healing sores
□ Change in an appearance of a mole
□ Bruising easily
□ Breast pain
□ Breast lump
□ Other: _____
□ None in this category

ENDOCRINE AND HEMATOLOGIC
□ Thyroid problems
□ Diabetes
□ Excessive thirst or urination
□ Heat or cold intolerance
□ Hormone problems
□ Anemia
□ Immune system disorder
□ Difficulty gaining/losing weight
□ Low libido
□ Infertility
□ Other:_____
□ None in this category

Women Only:
□ Painful menstrual cycles
□ Irregular menstrual cycles
□ Hot flashes
□ Infertility
□ Date of last menstrual period _____
□ Other: _____
□ None in this category

Pregnancies:

Date	Outcome

Comments: _____

I have read the above information and certify it to be true and correct to the best of knowledge, and herby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statues.

Patient or Guardian Signature: _____ Date: _____

Treating Doctor Signature _____Date: _____

ROBERTSON CHIROPRACTIC, LLC: Patient Health Information Notice of Privacy Agreement

Consent for purposes of treatment, payment and healthcare operations

I consent to the use or disclosure of my protected health information by ROBERTSON CHIROPRACTIC, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ROBERTSON CHIROPRACTIC, LLC. I understand that diagnosis or treatment of me by Danielle Robertson, D.C. or other doctors at ROBERTSON CHIROPRACTIC, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ROBERTSON CHIROPRACTIC, LLC is not required to request, the restriction is binding on ROBERTSON CHIROPRACTIC, LLC and Danielle Robertson, D.C. Unless ROBERTSON CHIROPRACTIC, LLC is notified otherwise, I consent to being contacted by ROBERTSON CHIROPRACTIC, LLC by telephone, mail or other electronic means in order to confirm appointments, advise me of any shift closings, provide newsletters or invite me to any special events. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work mobile. I also consent to having my picture taken in order for the doctors to help analyze my posture and for my Electronic Health Records.

I have the right to revoke this consent, in writing, at any time, except to the extent that Danielle Robertson, D.C. or ROBERTSON CHIROPRACTIC, LLC has taken action in reliance on this consent.

My *protected health information* means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in the closed, private exam room. A doctor or trained staff member will speak with you about your condition or other matters in the closed, private exam room.

Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply me with a copy of the office privacy policies and procedures upon request. I understand I have a right to review and have a copy provided to me, upon my request, of ROBERTSON CHIROPRACTIC, LLC's notice of privacy practices prior to signing this document. The notice of privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the ROBERTSON CHIROPRACTIC, LLC.

This notice of privacy practices also describes my rights and ROBERTSON CHIROPRACTIC, LLC's duties with respect to my protected health information.

ROBERTSON CHIROPRACTIC, LLC reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of patient or parent/legal guardian _____ Date _____/_____/_____

Witness of patient or parent/legal guardian _____ Date _____/_____/_____

Patient name: _____

AUTHORIZATION TO RECEIVE MEDICAL RECORD INFORMATION

Dr. Danielle Robertson, D.C. or other doctors at ROBERTSON CHIROPRACTIC, LLC, is hereby authorized to request the release of any medical records, laboratory test results and radiographic and diagnostic imaging results, pertinent to the health care of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney or other health care provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Dr. Danielle Robertson, D.C. or other doctors at ROBERTSON CHIROPRACTIC, LLC, is also authorized to release any medical records pertinent to the health care of the above named patient to, but not inclusive or, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such discloser may contain information confidential in nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by said Dr. Danielle Robertson, D.C.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various models of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Danielle Robertson D.C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or service as back-up for Dr. Danielle Robertson, D.C. including those working at the ROBERSTON CHIROPRACTIC, LLC.

By reading below, I have been made aware that the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra€ of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound; as an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, head or cold.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some occasional risks to treatment including, but not limited to, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I also am made aware that the chiropractor has made no guarantee of a positive outcome from treatment.

I understand I will have the opportunity to discuss with the doctors of ROBERTSON CHIROPRACTIC, LLC, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

FINANCIAL RESPONSIBILITY:

Payment is due when services are rendered unless prior arrangements (including insurance participation) have been made. The individual(s) above understands that a $30 returned check fee will be charged should payments be made via check. The above individual(s) will also be responsible for any appropriate collection or attorney's fees which may accrue if it is necessary to engage collection services to pursue payment of any outstanding balance. I understand that ROBERTSON CHIROPRACTIC, LLC will file initial insurance claims. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered. 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 ROBERTSON CHIROPRACTIC, LLC enough to meet our cost of service. 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, judgement, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(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 ROBERTSON CHIROPRACTIC, LLC for any and all treatment, products & services rendered to the patient or minor shown below.

CMS-1500 HEALTH INSURANCE CLAIM FORM:

By signing below, I acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGANTURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government belongs either to myself or to the party who accepts assignment below". Box 13 Reads as follows: "INSURED'S OR AUTHORAIZED PERSON'S SIGANTURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF TREATMENT PLAN:

By signing below, I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

Signature of patient or parent/legal guardian _____ Date _____/_____/_____

Witness of patient or parent/legal guardian _____ Date _____/_____/_____