Patient #
Completed by office

Decker Chiropractic Walk-In-Care, PA

13025 S Mur-Len Road Suite 100 Olathe KS 66062 | Phone Number: 913-829-5111 | Fax: 913-829-5179

Patient Information

Date: | Birthday:

First Name: | Middle Name: | Last Name:

Sex: ◯M ◯F | Height: | Weight:

Marital Status: ◯Yes ◯No | Spouse Name: | # of Children:

Home #: | Cell #: | Work #:

Address:

City: | State: | Zip:

Patient Email

Emergency Contact: | Emergency Relation | Emergency Phone:

Insured Information
(person the insurance policy is under)

Full Name: | Sex: | Birthday:

Address: | Phone:

Relationship: | Insurance Company:

Referral Information

Referring Physician: | Referred by:

Advertisement: ◯Yes ◯No | Advertisement:

Employer Information

Employer Title: | Job Title:

Employer Address | City, State, Zip

Supervisor Name:

Complaint Information

Injury Occurred: ◯Automobile ◯Work ◯Third-Party ◯Other: | Injury Date:

Injury Origin:

Describe Discomfort:

Frequency: ◯Always ◯Hourly ◯Daily ◯Occasionally

Interfere w/ Activities: ◯Yes ◯No | Affected Sleep: ◯Yes ◯No

Missed Work: ◯Yes ◯No | Unable to Work from: | Unable to Work until:

Affected Appetite: ◯Yes ◯No | Explain:

Reduced Work: ◯Yes ◯No | Explain:

Does it Worsen: ◯Yes ◯No | Explain:

Weather Affects it: ◯Yes ◯No | Explain:

Aggravates Condition:

Improves Condition:

Received Treatment: ◯Yes ◯No | Explain:

X-Rays Taken: ◯Yes ◯No | Explain:

Same Condition Before: ◯Yes ◯No | Date: | Practitioner:

History

Last Physical Exam:			Primary Physician:			Phys Phone #
Phys City:			Phys State:			Phys Zip:
Health Conditions						
Previous Chiro Care:	◯ Yes	◯ No	Date:			Explain:
Chance Pregnant:	◯ Yes	◯ No	Planning:	◯ Yes	◯ No	
Medications:						
Supplements:						
Broken Bones:	◯ Yes	◯ No	Treatment:	◯ Yes	◯ No	Explain
Sprains/Strains:	◯ Yes	◯ No	Treatment:	◯ Yes	◯ No	Explain
Hospitalized:	◯ Yes	◯ No	Explain:			
Surgery:	◯ Yes	◯ No	Explain:			
Auto Accident:	◯ Yes	◯ No	Treatment:	◯ Yes	◯ No	Explain
Struck Unconscious:	◯ Yes	◯ No	Treatment:	◯ Yes	◯ No	Explain
Eating Disorder:	◯ Yes	◯ No	Explain:			
Stroke:	◯ Yes	◯ No	Explain:			
Family Health History:						

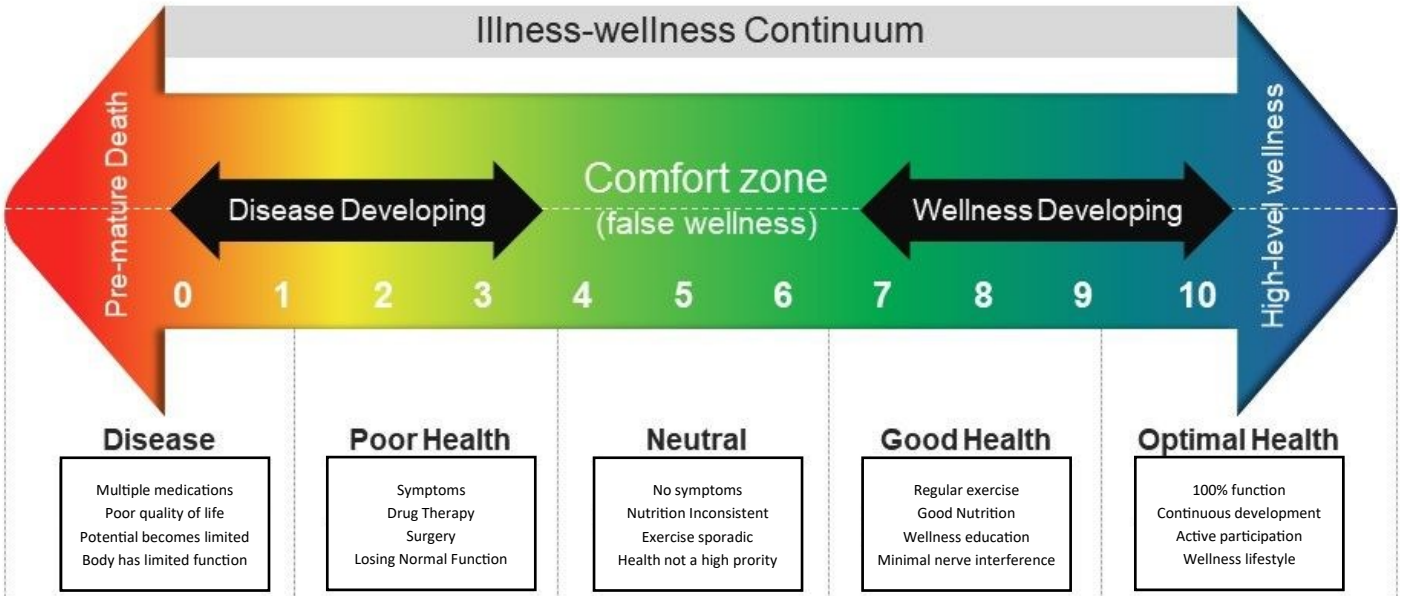
Patient Social

Alcohol	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Diet Food Products	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
OTC Stimulants	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Homemade Food	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Soft Drinks	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Water	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Caffeine	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Drugs	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Exercise	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Processed Food	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never
Tobacco/Vaping	◯ Daily	◯ Weekly	◯ Occasionally	◯ Never

Health Checklist

☐ Allergies	☐ Cramps	☐ Irregular Menstrual Cycle	☐ Sinus Infection
☐ Alcoholism	☐ Depression	☐ Kidney Infection	☐ Insomnia
☐ Anemia	☐ Diabetes	☐ Kidney Stones	☐ Spinal Curvatures
☐ Arteriosclerosis	☐ Digestion Problems	☐ Loss of Memory	☐ Stroke
☐ Arthritis	☐ Dizziness	☐ Loss of Balance	☐ Swelling of Ankles
☐ Asthma	☐ Excessive Menstruation	☐ Loss of Smell	☐ Swollen Joints
☐ Back Pain	☐ Eye Pain or Difficulties	☐ Loss of Taste	☐ Thyroid Condition
☐ Breast Lump	☐ Fatigue	☐ Nosebleeds	☐ Tuberculosis
☐ Bronchitis	☐ Frequent Urination	☐ Pacemaker	☐ Ulcers
☐ Bruise Easily	☐ Headache	☐ Polio	☐ Varicose Veins
☐ Cancer	☐ Hemorrhoids	☐ Poor Posture	☐ Venereal Disease
☐ Chest Pain	☐ High Blood Pressure	☐ Prostate Trouble	Other:
☐ Cold Extremities	☐ Hot Flashes	☐ Sciatica	
☐ Constipation	☐ Irregular Heart Beat	☐ Shortness of Breath	

Health Goals



On the arrow diagram above:

What number do you think represents your health today?

In what direction is your health currently headed?

What are your health goals?

Immediate:

Short term:

Long term:

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ◯ **I want the Doctor to select the type of care appropriate for my condition.**
- ◯ **Relief Care:** Symptomatic relief of pain or discomfort.
- ◯ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- ◯ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

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Wellness Survey

Please fill out the questionnaire prior to your appointment. This information will contribute to the development of a nutritional program based on your needs and current lifestyle habits. Please feel free to include any additional information that you feel might be relevant to your current situation.

Patient Name _____

Do you take a daily multivitamin?	Yes ◯	No ◯								
Do you take vitamin D?	Yes ◯	No ◯								
How are you sleeping? (1 bad, 5 great)	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯					
How many hours per night?	_____									
Do you eat fish on a daily basis?	Yes ◯	No ◯								
Do you eat enough fruits and vegetables each day?	Yes ◯	No ◯								
How would you rate your gut health? (1 bad, 5 great)	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯					
How diverse if your daily diet? (1 not diverse, 5 very diverse)	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯					
Do you suffer from inflammation or chronic pain?	Yes ◯	No ◯								
Rate your overall health (1 bad, 10 great)	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯

Please describe any areas of your health you would like to improve:

Supplements - List all supplements you are currently taking:

Do you have any supplement questions?

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Financial Policy

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your cash, check or credit card.

GROUP OR INDIVIDUAL INSURANCE
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

"ON THE JOB" INJURY (Worker's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 3 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON•
COVERED. These services include but are not limited to, X-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services, Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

INSURANCE FORMS/PAYMENT
If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

MISSED APPOINTMENTS
Any new or established patient who fails to arrive for a scheduled appointment will be charged a fee of $25. Please give us the courtesy of a phone call to cancel and/or reschedule to avoid this charge.

I have read and understand the payment policy of Decker Chiropractic, I understand that my insurance is an arrangement between myself and my insurance company, NOT between Decker Chiropractic and my insurance company, I request that Decker Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Decker Chiropractic that fees will be due and payable immediately.

Patient's Signature (or guardian if patient is a minor) Date

Decker Chiropractic Walk-In-Care, PA

13025 S Mur-Len Road Suite 100 Olathe KS 66062
Phone Number: 913-829-5111
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Addendum to Notice of Privacy Practices • HIPAA

I give permission to release information to the following person or persons. He and/or she may inquire in person, by phone, or mail about my account or records and speak with the doctor on my behalf.

☐ None

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

I give permission to release information about my chiropractic care and my progress to the medical doctor listed below:

Doctor's name

Office Address	City, Zip
Office Phone	

Signature: _____ Date: _____

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HIPAA 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 CAREFULLY.

If you have any questions about the above notice, please contact our Office at 913-829-5111

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

HIPAA Notice of Privacy Practices (continued)

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

L**aw Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

HIPAA Notice of Privacy Practices (continued)

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may have used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our
office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient Signature _____ Date _____

Decker Chiropractic Walk-In-Care, PA

13025 S Mur-Len Road Suite 100 Olathe KS 66062
Phone Number: 913-829-5111
Fax: 913-829-5179

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment (s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Patient Name _____ Date _____

Patient Signature _____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the

doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. 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 known, is in my best interest.

I have read, and or have had read to me, the above consent. I have also had an 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 condition (s) for which I seek treatment.

To be completed by patient:

Print Patient's Name

Patient Signature (or legal guardian if under 18)

Date Signed

To be completed by doctor or staff:

Name and Address of clinic/office:

Decker Chiropractic Walk-In-Care, PA
13025 S Mur-Len Road, Suitel00 Olathe, KS 66062
913-829-5111

Print name (s) doctor (s) treating this patient:

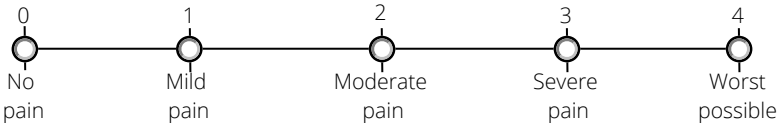
George D Decker, D.C.

Functional Rating Index

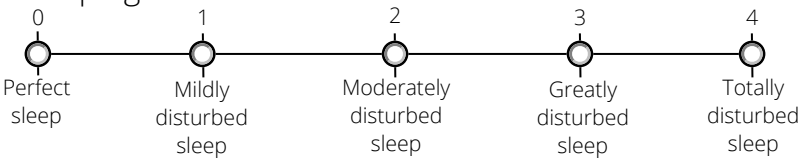
For use with ***NECK*** problems only.

In order to properly assess your condition, we must understand how much your neck problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

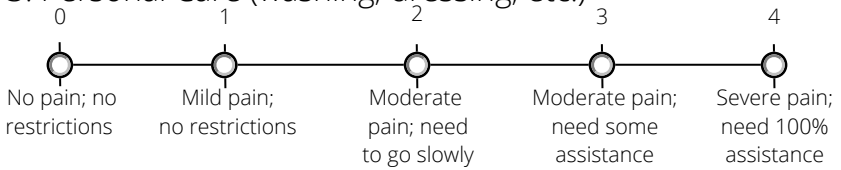
1. Pain Intensity



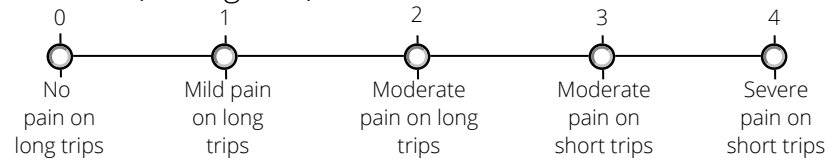
2. Sleeping



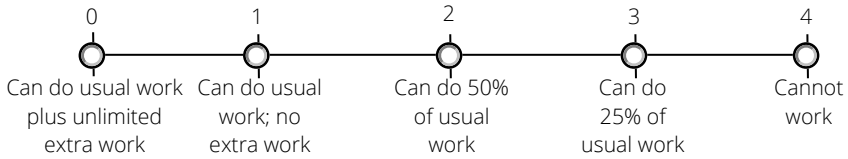
3. Personal Care (washing, dressing, etc.)



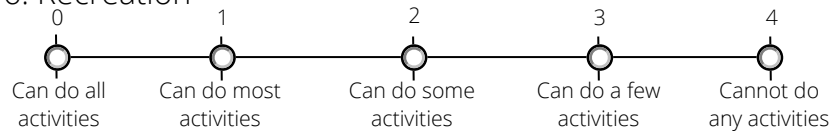
4. Travel (driving, etc.)



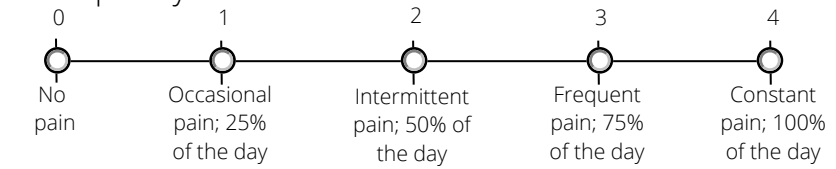
5. Work



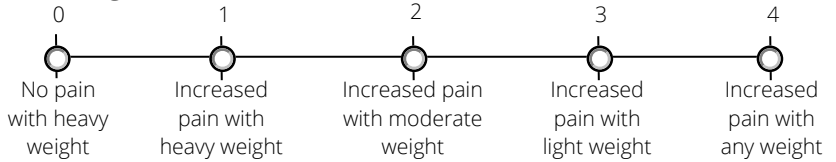
6. Recreation



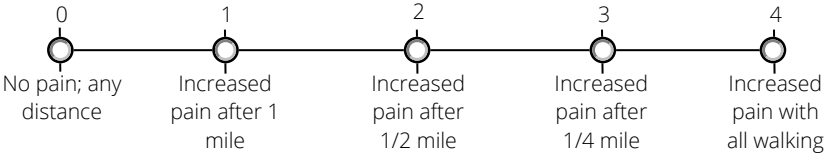
7. Frequency of Pain



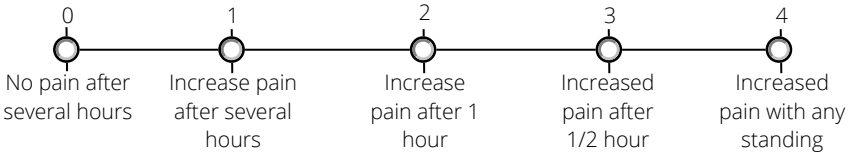
8. Lifting



9. Walking



10. Standing



Name: _____

Score: _____

Signature: _____

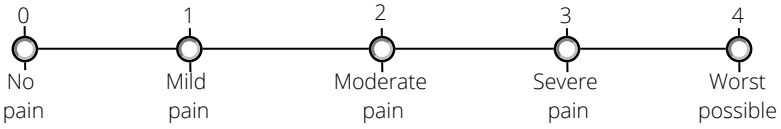
Date: _____

Functional Rating Index

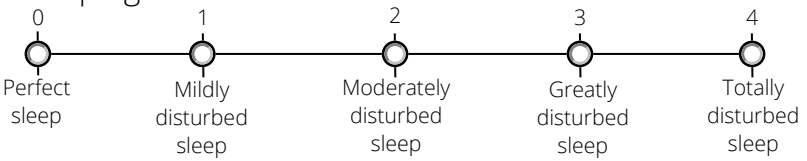
For use with ***BACK*** problems only.

In order to properly assess your condition, we must understand how much your back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

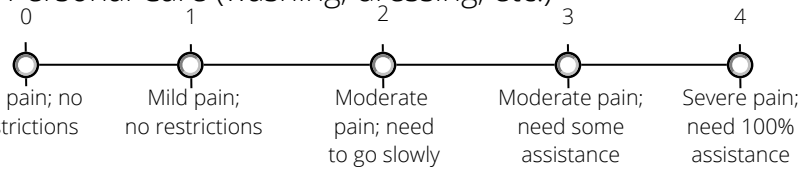
1. Pain Intensity



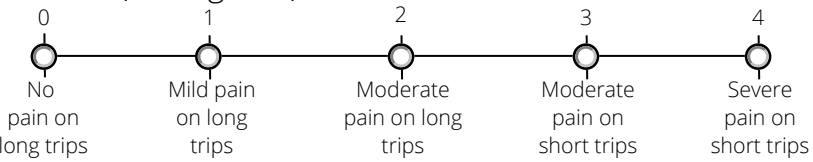
2. Sleeping



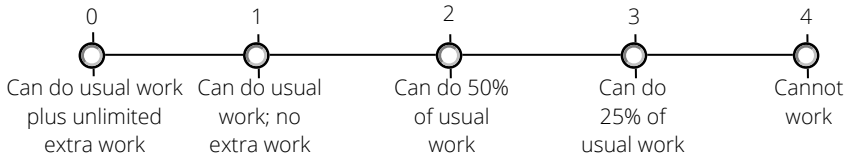
3. Personal Care (washing, dressing, etc.)



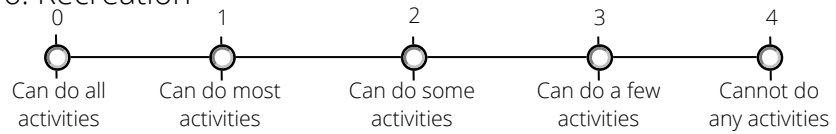
4. Travel (driving, etc.)



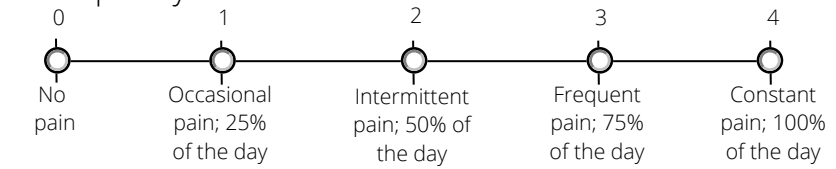
5. Work



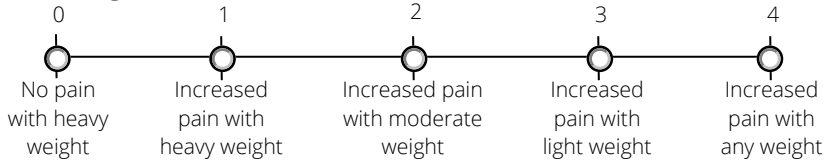
6. Recreation



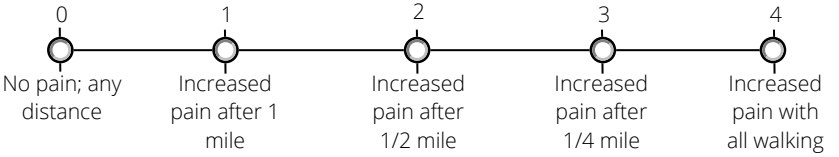
7. Frequency of Pain



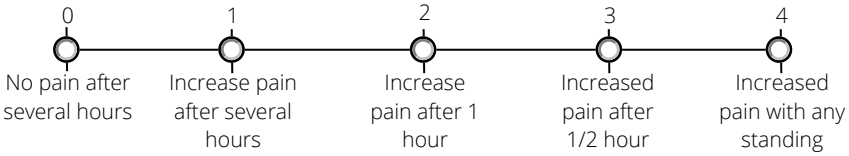
8. Lifting



9. Walking



10. Standing



Name: _____

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