NEW PATIENT REGISTRATION

Name_____ Age_____ Sex____ Date of Birth_____

Address_____City_____State_____ Zip_____

Phone (H)_____ (W)_____ (C) _____

SS #_____ Marital Status: ( )Married ( )Divorced ( )Single Spouses Name_____

Employer_____ Spouses Employer_____

Family Dr. _____ Doctors Phone # _____

In Case of Emergency Call_____ Phone #_____ Relation_____

Email Address_____ Can we send info to your email address? Yes ___ No ___

Welcome to the Utterback Chiropractic, LLC, dba Kirkwood Spine and Rehab clinic. Our highly trained staff is always willing to help you and your family. Our practice grows from referrals and we appreciate you in a very special way when you recommend your family and friends to our office.

Office hours allow our patients the convenience to schedule appointments before and after work as well as during lunch. We are usually available to see new patients the same day or through our 24 hour- 7 day emergency service.

The doctor will discuss your health history, perform an examination and discuss recommendations with you today. There are no guarantees or promises of improvement or complete recovery. Please give the doctor as much information as you can remember. By this registration you authorize the doctor to perform such examinations, diagnostic tests and/or treatment as he may consider medically necessary and you authorize us to release all information to your health insurance company and/or all applicable parties on your behalf.

Payment

1. Patient payments are collected at time of visit, including copays, co-insurance, deductibles and all non-covered charges. Due to the variations among insurance companies, we will estimate your portion to the best of our ability. Any balances due will be expected at the time of billing.
2. We accept cash, personal check, visa, MasterCard and Discover.
3. Returned checks, debit and credit charges due to insufficient funds, stopped payments or other reasons of non payment will be assessed a $30 charge.

Health Insurance

1. We do accept most insurance plans and most insurance plans do cover chiropractic care. It is YOUR responsibility to give the correct information about your insurance accompany and YOUR responsibility to follow the rules outlined by your insurance plan (i.e. Referrals).
2. We will call your insurance company to verify your chiropractic coverage. We will collect any copayment and or deductible amounts quoted by your insurance at the time services are rendered. If there are any discrepancies when the claims are processed you may be responsible for any additional monies. Please look at your explanations of benefits sent to your home from your insurance company. We advise you to contact your insurance company to verify your benefits. If you are told different benefits, please advise our office.
3. We will submit all claims for services rendered in our office to your insurance company.
4. We feel all procedures performed in our office are medically necessary. However, some insurance companies in an attempt to save cost, will consider some services as "non-covered" or "not medically necessary". Any services which are denied will be your responsibility.

Accidents – Auto/Other

1. If you are being treated for injuries sustained in an accident (automobile/other) you agree that your personal med pay and/or party at fault insurance company will be responsible for reimbursement of treatment provided.
2. A signed lien is REQUIRED for treatment in this office.
3. If you are dealing with an auto insurance company or involved in a lawsuit that affects the payment of the services rendered, please be advised that payment is due no later then 90 days of discharge from our office, whether or not your case has settled. It is YOUR responsibility to stay on top of your case with the party at fault insurance and/or your attorney.

Medicare

We do not accept Medicare assignment. Medicare members must pay in full at the time services are rendered. We will submit claims to Medicare and any reimbursement they make will be sent directly to you. It is your responsibility to make our staff aware if you have a secondary insurance and if you are set up for cross over.

Overdue Accounts

Any patient portion unpaid after 90 days from the date of service will be subject to an 18% charge. If your balance remains unpaid it will be sent to a collection agency or an attorney for nonpayment.

Missed Appointments

A missed appointment fee of $10 will be charged for no shows and appointments cancelled without 24 hour notice.

By your signature below, you agree to the terms set out in this registration.

Signature _____ Date_____ 01/15/14

140 W. Adams Ave.
Kirkwood, MO 63122
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F 314.965.8612
www.kirkwoodspineandrehab.com

Dr. Jacob H. Utterback
Chiropractic Physician
kirkwoodspine@gmail.com

Kirkwood Spine & Rehab

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

This PHI Consent will be part of your medical record at this facility.

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REASON FOR VISIT

What is/are your complaints? _____

_____

When did these symptoms begin (most recent episode)?: _____

_____

Have you had these symptoms in the past? ☐ Yes ☐ No If So, Explain: _____

_____

How did the symptoms begin: ☐Auto Accident ☐Work Accident ☐Fall

☐ Other (please explain): _____

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily Routine

☐ Other (please explain): _____

How often do you experience your symptoms?

☐ Constantly (75%-100% of the day) ☐ Frequently (50%-75% of the day)

☐ Occasionally (25%-50% of the day) ☐ Intermittently (0%-25% of the day)

What best describes your symptoms?

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Burning ☐ Shooting ☐Tingling

Since your symptoms began, have they been:

☐ Getting Worse ☐ Getting Better ☐ No Change

How do you rate your overall health?:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐Poor

Have you seen any other healthcare professionals for this condition?: ☐ Yes ☐ No

If so, Who?:_____ Phone Number:_____

What treatment did your receive? _____

Were X-rays/MRI/Tests etc. performed? ☐ Yes ☐No If So, Where?: _____

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HEALTH HISTORY

Do you currently or have you had in the past any of the following (Please check and explain below, if necessary):

- ☐ Heart Attack
- ☐ Stroke
- ☐ Congenital Heart Defect
- ☐ High / Low Blood Pressure
- ☐ Heart Murmur
- ☐ Fainting/Seizures/Epilepsy
- ☐ Diabetes
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Anemia
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Headaches
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Venereal Diseases
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Emphysema
- ☐ Alcohol / Drug Abuse
- ☐ HIV / AIDS
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Cancer
- ☐ Ulcers / Colitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Artificial Bones / Joints
- ☐ Birth Defects

Please list any other serious medical conditions you have had or provide explanation for above: _____

_____

Are you taking any medications?: ☐ Yes ☐ No

If Yes, Please List: _____

Do you have any allergies?: ☐ Yes ☐ No

If Yes, Please List: _____

Please list any previous surgeries: _____

Please list any past accidents/falls/trauma with dates: _____

_____

Family health history (i.e. cancer, anemia, diabetes, high/low blood pressure):

_____

Do you take supplements or vitamins? ☐ No ☐ Yes, list: _____

Do you exercise? ☐ Yes ☐ No If Yes, how often? _____

Are you on a special diet? ☐ Yes ☐ No If Yes, Please Explain _____

Do you smoke? ☐ Yes ☐ No How Much? _____ For how long: _____

Do you wear: ☐ **Heel Lifts** ☐ **Orthotics** ☐ **Arch Supports** ☐ **Other:** _____

For women: Are you pregnant? ☐No ☐Yes/How long? _____; Nursing ☐ Yes ☐ No

Are you taking birth control? ☐ Yes ☐ No

• **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

SIGNATURE: _____ **DATE:** _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

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PAIN DRAWING

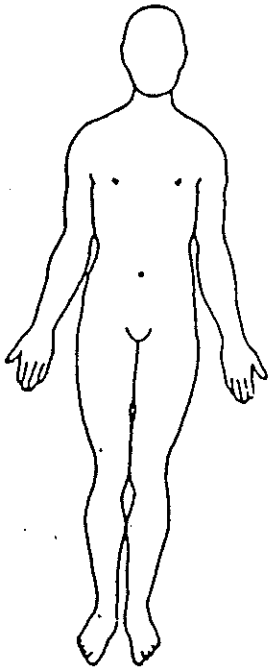
Patient Name:_____ Acct:_____ Date:_____

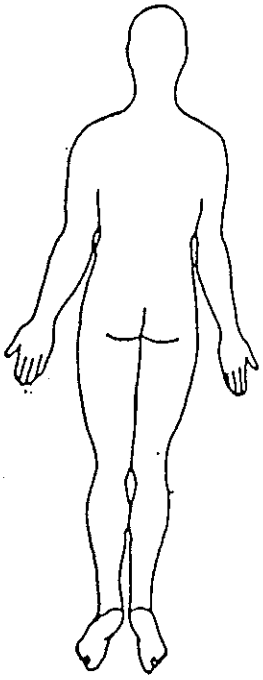
Draw location of your pain on body outlines and mark how bad it is on pain line.

PAIN SCALE 1 = Mild 10 = Severe

PAIN DRAW Pain = :::::::::::::::::::::::::::: Numbness = ++++++++++++

Ache = ********** Burning =//////////////

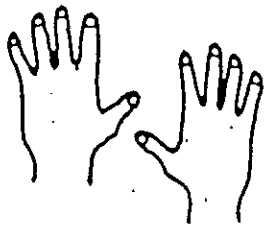




HANDS.

FEET

Tops **Palms**



Tops **Soles**