



InMotion Chiropractic Health Center P.C.

7800 Clayton Road

Richmond Heights, MO 63117

(314) 644-2081

fax (314) 644-2309

Tax ID # 43-1732700

ESTABLISHED PATIENT CASE HISTORY

Please complete this questionnaire if you have a new injury. Your answers will help us determine if our clinic can help you. If we do not sincerely believe your condition will respond satisfactorily to chiropractic or acupuncture care, we will direct you to the appropriate physician who, we feel, is best suited to give you the necessary care. Thank you for your cooperation.

Name: _____ Social Security No.: _____

Please update the following information if it has changed since we last saw you:

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

Home Telephone: _____ Work Telephone: _____ Age: _____ Birthdate: _____

Occupation: _____ Marital Status: M S W D Number of Children: _____

Spouse's Name: _____ Spouse's Office Telephone: _____

Referred by: _____ Nearest Relative and Telephone: _____

Email Address: _____

HEALTH INFORMATION:

What is your major complaint? _____

Onset of complaints/condition: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other: _____

Do other family members have similar problems? Yes No Please list: _____

Other doctors who treated this condition: _____

List surgical operations and years: _____

Drugs you now take: _____

Have you been in an auto accident: Past year Past 5 years Over 5 years Never

Please describe: _____

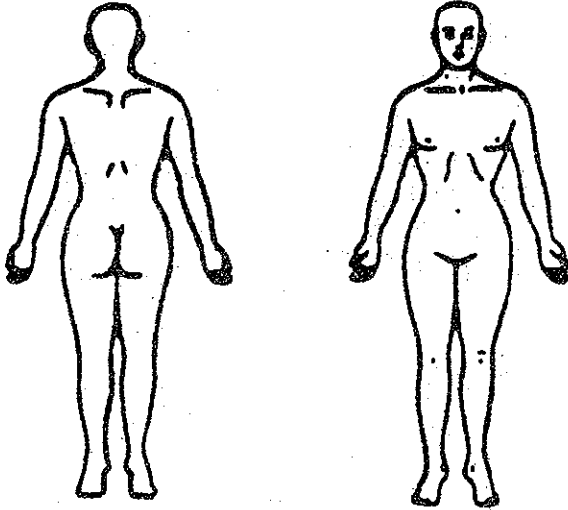
Have you had any other personal injury, job related injury or accident?

Past year Past 5 years Over 5 years Never

Describe: _____

Date of last physical examination? _____

Please mark your areas of pain on the figures below:



Have you ever suffered from:

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

Family Health Information

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? Yes No

Do you have Health Insurance? Yes No Name of Company: _____ Policy No.: _____

Are you covered by Medicare? Yes No If yes, Health Insurance Number _____

I understand and agree that health and accident policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this Health Care Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Health Care Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by Cash Check Credit Card

Mastercard Visa Card # _____ Exp. Date _____

All accounts not paid within 90 days will *automatically* be put through on your credit card.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ S.S. # _____

Consent to Examination

I authorize the performance of any physical evaluation of myself, my above named child or the above named ward, which the doctor may consider necessary or advisable in the course of my examination.

Authorized Signature: _____ Date: _____

AGREEMENT

To Office Policy and Procedures

1. I agree to the following appointment schedule. I understand that if I must cancel, I agree to do so 4 hours prior to my scheduled appointment time. I will be expected to make up any missed appointments. All missed appointments must be made up within seven (7) days (barring any emergencies, vacations or trips out of town.) Failure to make up any missed appointment will result in a service charge of \$ 25.00 and will be billed to me directly and is not payable by insurance, lien, workers compensation, etc.
2. I agree to follow all other recommendations made by the doctor(s), including the proper use of my spinal supports, doing my excercises as prescribed, etc.
3. I understand that any recommendation for future care will be made only after physical and/or x-ray examination.
4. I understand when arriving for each office visit, I will sign in at the front desk. If I am late, I understand that I may have to wait for the next available appointment or reschedule for another time.
5. There will be a \$35.00 charge (additional to bank charge) for returned checks (insufficient funds). If your account is sent to a collection agency, a 35 to 50% collection fee will be added.
6. We submit Chiropractic services to your insurance if benefits are available. **However, acupuncture and massage are non-billable services in our office.**
7. Multiple appointments should be scheduled in advance for your convenience. It is the frequency of visits that provide the greatest benefits.
8. Please do not leave valuables in any room, on the coat rack, or in the waiting room. We cannot be responsible for them.
9. I agree that I have read the Office Policy and Procedures and understand it.

Signature of Responsible Party, Parent or Guardian

Date

Print Patient's Name

InMotion Chiropractic Health Center, P.C.

Patient Consent to uses of Protected Health Information (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health information," or (PHI) for short. It includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care.

We may use and/or disclose your PHI for reasons relating to treatment, payment or health care operations, with your signed consent. However, there are certain uses and disclosures which do not require your consent such as: when it is required by law, for health oversight activities, for research purposes, to avoid harm, for specific government functions, and for workers' compensation purposes. This also includes appointment reminders and health-related activities, fundraising/marketing efforts, and disclosures to family, friends and others that you indicate being involved in your care or payment for your care.

Your rights regarding your PHI allow you to request limits on the uses and disclosures of this information. We do require such requests in writing. We will consider your request, but are not legally required to accept it. If we do accept your request, we will abide by it except in emergency situations. You may not limit the uses and disclosures we are legally required or allowed to make. Furthermore, you have the right to revoke this signed consent in writing.

For further information, you may request a copy of the Notice of Privacy Practices from the front desk. This notice can also be found throughout the office in the waiting room and treatment rooms. It outlines in detail how your PHI may be used both with and without your consent, your rights regarding your PHI, and how to file a complaint about the privacy practices at InMotion Health Center,

By signing below you are stating that you understand, and agree to your protected health information being subject to the standard uses and disclosure of the privacy practices at InMotion Chiropractic Health Center, P.C.

Signed: _____ Date: _____

Name: _____

(Please Print)