Confidential Patient Information

Today's Date: ____/____/_____

Patient Information:

First Name: _____ (Preferred Name: _____) Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code (please include suffix): _____-_____

Home Ph.: (_____) _____-_____ Work: (_____) _____-_____ Ext. _____ Cell.: (_____) _____-_____

Birthday: _____/_____/_____ Age: _____ Sex: [] Male [] Female

Social Security Number: _____-_____-_____ E-Mail Address: _____

Marital Status (check one): [] Single [] Married [] Widowed [] Separated [] Divorced

Race: [] American Indian or Alaskan [] Asian [] Black [] Caucasian

Ethnicity: [] Hispanic [] Non-Hispanic [] Declined

Language: [] English [] Spanish [] French [] Other (please specify)_____

Associations:

Employment \ Student Status (check one): [] Employed Full Time [] Retired [] Student [] Not Employed
[] Employed Part Time [] Other: _____

Employer Information-

Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Occupation \ Job Description: _____

Whom may we thank for referring you to our office? _____

[] Dr. Lukert [] Family \ Friends [] Other Patients [] Your Primary Care Physician [] Insurance Provider Directory [] Other

Are we seeing you today as a result of an accident or injury? _____ [] Workman's Comp [] Auto Accident

Who is your Primary Care Physician? _____ Clinic Name & Location? _____

When did your current complaints begin and where are they located?

_____

_____

_____

Primary Insurance:

Insurance Company Name: _____

Policy \ Group Number: _____

ID Number: _____

Insured Information (if other than self):

Name: _____

Address: _____

City: _____ State: ___ Zip Code: _____

Birthday: ____/____/_____

Social Security Number: _____-_____-_____

Relation to Insured: _____

Insured Employer: _____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____

Secondary Insurance:

Insurance Company Name: _____

Policy \ Group Number: _____

ID Number: _____

Insured Information (if other than self):

Name: _____

Address: _____

City: _____ State: ___ Zip Code: _____

Birthday: _____/_____/_____

Social Security Number: _____-_____-_____

Relation to Insured: _____

Insured Employer: _____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____

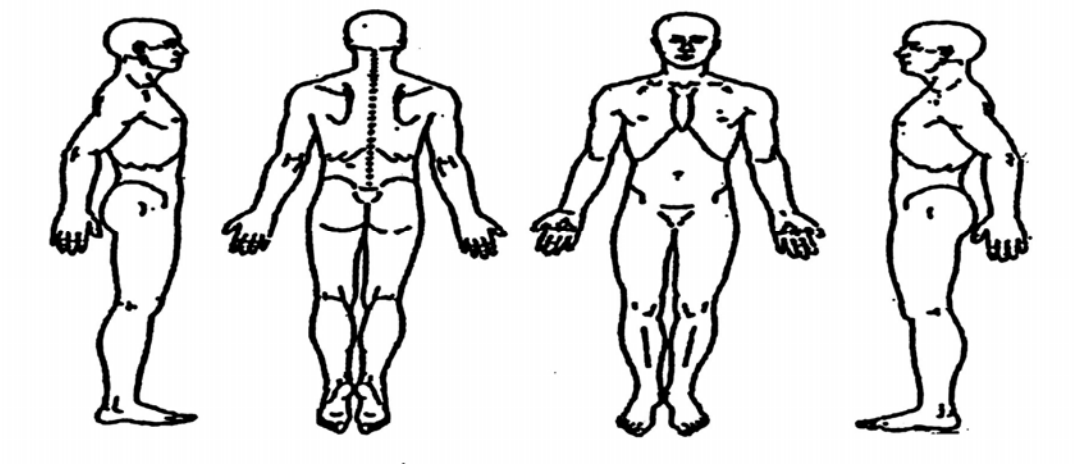
Patient Intake Form

Patient Name: _____ Date: _____

1. Are we seeing you today as a result of an accident or injury? _____ [] Workman's Comp [] Auto Accident

2. What date did your accident/injury occur? ____/____/____

3. Indicate on the drawings below where you have pain/symptoms:



4. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

6. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

□ Not at all □ Slightly □ Moderately □ Substantially □ Extremely

9. How much has the problem interfered with your social activities?

□ Not at all □ Slightly □ Moderately □ Substantially □ Extremely

10. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

11. How long have you had this problem? _____

12. How do you think your problem began?

_____

13. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

14. What alleviates your problem?

_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. What aggravates your problem?

_____

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17. What is your: Height_____ **Weight** _____ **Date of Birth** _____
Occupation _____

18. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

19. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

20. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ Chronic Sinusitis	□	□ Visual Disturbances
□	□ Neck Pain	□	□ High Blood Pressure	□	□ Dizziness
□	□ Upper Back Pain	□	□ Heart Attack	□	□ Diabetes
□	□ Mid Back Pain	□	□ Chest Pains	□	□ Excessive Thirst
□	□ Low Back Pain	□	□ Stroke	□	□ Frequent Urination
□	□ Shoulder Pain	□	□ Angina	□	□ Smoking/Tobacco Use
□	□ Elbow/Upper Arm Pain	□	□ Kidney Stones	□	□ Drug/Alcohol Dependency
□	□ Wrist Pain	□	□ Kidney Disorders	□	□ Allergies
□	□ Hand Pain	□	□ Bladder Infection	□	□ Depression
□	□ Hip Pain	□	□ Painful Urination	□	□ SLE
□	□ Upper Leg Pain	□	□ Loss of Bladder Control	□	□ Epilepsy
□	□ Knee Pain	□	□ Abnormal Weight Change	□	□ Dermatitis
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ HIV/AIDS
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Ulcer	**For Females Only**	
□	□ Arthritis	□	□ Hepatitis	□	□ Birth Control Pills
□	□ Rheumatoid Arthritis	□	□ Liver/Gallbladder Problems	□	□ Hormonal Replacement
□	□ Cancer	□	□ General Fatigue	□	□ Pregnancy
□	□ Tumor	□	□ Muscle In-coordination		
□	□ Asthma				

22. List all medications you are currently taking:
_____

23. List all supplements you are currently taking:
_____

24. List all surgical procedures you have had:
_____

25. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drive:**	□ Most of the day	□ Half of the day	□ A little of the day

□ **Perform manual labor**
□ **Reads a lot**
□ **Travels frequently**

26. What activities do you do outside of work?
_____

27. Have you ever been hospitalized? □ No □ Yes
If yes, why? _____

28. Have you seen a chiropractor before? □ No □ Yes **How long ago?** _____
29. What was the result of your chiropractic treatment? _____
30. Have you had significant past trauma? □ No □ Yes
Please explain the past trauma:_____

31. Anything else pertinent to your visit today? _____

Patient Signature_____ **Date:** _____

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Office Policy

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

THE NO CHARGE CONSULTATION:

We will perform a special "no charge" consultation, or brief conference, with anyone interested in finding out more about chiropractic care, and if it can relieve your condition. There is no charge or obligation in association with this appointment.

APPOINTMENTS:

In order to better serve our patients, we ask that you call if you are unable to make your appointment, or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else, please help us help others.

QUESTIONS AND ANSWERS:

Your questions about any aspect of your care are encouraged. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries.

HIPAA GUIDELINES:

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this office is, to the best of our knowledge, compliant with all rules and regulations set forth under HIPAA. This will require you to read and acknowledge additional documents concerning how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

INSURANCE INFORMATION:

Most insurance policies do cover chiropractic care. However, if yours does not, we encourage you to urge your employer or health insurance broker to change your policy to one that does. Your freedom to choose your own healthcare provider is a fundamental right. If we can help in any way, please let us know. We do offer patient payment plans for those individuals lacking health insurance.

It is important that you understand that health and accident insurance policies are an arrangement between yourself and your insurance carrier. Of course, we will prepare and provide any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, any amount authorized to be paid directly to us will be credited to your account upon receipt.

However, you must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment. In order to facilitate that correct and rapid processing of your insurance claim, we suggest the following:

- Call your insurance agent to determine exactly what coverage you have. Ask what deductible, if any, applies to your policy. Then, ask how much of your claim the company will pay.
- It is a good idea to know your insurance coverage. However, if you have questions, feel free to ask our staff. We are experienced in insurance claims handling and will be happy to help in any way we can.

We will call your insurance provider for an explanation of your plan benefits. This is a general summary of the benefits available to you under your plan, and is not intended to be used as an authorization for services or as a guarantee of benefits. Your specific plan exclusions and limitations will be applied at the time the claim is processed, which can range from several weeks to over a month. Your eligibility and benefits are based on the information currently available to us and are subject to change without prior notification. All benefits are

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subject to your plan's pre-existing condition limitations as specified in the plan. All covered charges will be limited to reasonable and customary charges. Benefits may also be coordinated with another carrier if other coverage is involved. Ultimately, this is your insurance and final responsibility is yours to assume. *COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.*

INFORMED CONSENT & THE DOCTOR-PATIENT RELATIONSHIP:

Chiropractic:
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care.

Analysis:
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and/or VSC are found, chiropractic adjustments and ancillary procedures may be given in order to restore spinal integrity. Normal spinal alignment allows uninterrupted nerve signal transmission throughout the body and gives the body an opportunity to maximize its inherent healing ability. When the nervous system is functioning at its optimal capacity, the body itself can now be regulated the way it was intended.

Diagnosis:
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medicine specialists. Every chiropractic patient should be mindful of his/her symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care:
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are beneficial and very safe. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, in this case, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise come to the attention of the doctor of chiropractic. The doctor of chiropractic provides a specialized, non-duplicating health service, but is available to work with other types of providers in your health care regimen.

TO THE PATIENT:
Please discuss any questions or problems with the doctor before signing this statement of policy. By signing below, you indicate that you have read and completely understand the foregoing policies.

_____ _____

Patient's Signature Patient's Name

_____

Date Signed

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Lukert Chiropractic & Wellness to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Lukert Chiropractic & Wellness's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lukert Chiropractic & Wellness reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lukert Chiropractic & Wellness Privacy Officer at 1102 S. Old HWY 75, Sabetha, KS 66534.

With this consent, Lukert Chiropractic & Wellness may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Lukert Chiropractic & Wellness may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Lukert Chiropractic & Wellness restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Lukert Chiropractic & Wellness's use and disclosure of my PHI to carry out TPO.

With this consent, Lukert Chiropractic & Wellness may use my name on the Healing Board, in the Testimonial Book or the company web site only when I, as a patient of The Lukert Chiropractic & Wellness ask to be placed on/in the Healing Board, Testimonial Book or the company web site.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lukert Chiropractic & Wellness may decline to provide treatment to me.

My signature below acknowledges my **Patient Consent for Use and Disclosure Of Protected Health Information** and that I have been offered a copy of the **Lukert Chiropractic & Wellness Notice Of Privacy Practices**.

_____
Signature of Patient or Legal Guardian

_____ _____
Printed Name of Patient or Legal Guardian Date