

Liberty Chiropractic Center
New Patient Information

Today's Date _____

Name _____ Home # _____ Cell # _____

Address _____ City _____ State _____ Zip _____

S.S.N. _____ Date of birth _____ Occupation _____ Years _____

Employer _____ Address _____

Work Phone _____ Spouse's Name _____

Present Complaint _____

Patient's relationship to insured _____

Name of insured _____ Insured S.S.N. _____

Address of insured _____

Employer of insured _____ Address _____

Insured's work phone _____ Birthdate of insured _____

Is this a work related injury? _____ How did you hear of our office? _____

Were you referred to our office? _____ If yes, by whom? _____

Are you currently under a doctor's care? _____ Doctor's name _____

Medications _____

Are you a smoker? _____ If so, how many per day? _____

FEMALE PATIENTS:

Are you pregnant or think that you may be pregnant? _____ Number of children _____

Patient Signature _____

Patient Email Address _____

Liberty Chiropractic Center

Patient Health Questionnaire

Patient Name _____ Date _____

Describe your symptoms: _____

When did the symptoms start? _____ How did your symptoms begin? _____

How often do you experience your symptoms?
Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently (0-25% of the day)

Please use the diagram below to indicate your pain pattern(s)

How are your symptoms changing?
Getting worse Not changing Getting better

What describes the nature of your symptoms?
Sharp Numb Shooting Dull Ache
Burning Tingling

On a scale of 0-10, with 0 as no pain, what is your present level?
0 1 2 3 4 5 6 7 8 9 10

How much has pain interfered with your normal work?
Not at all A little bit Moderately Quite a bit Extremely

How much has pain interfered with social activities?
Extremely Quite a bit Moderately A little bit Not at all

Have you had similar symptoms in the past?
Yes No

Who have you seen for your present condition?
No one other chiropractor medical doctor physical therapist
other _____

What treatment did you receive and when? _____

Please indicate any tests that you have had and when they were performed.
Xrays date _____ MRI date _____ CT scan date _____ other date _____

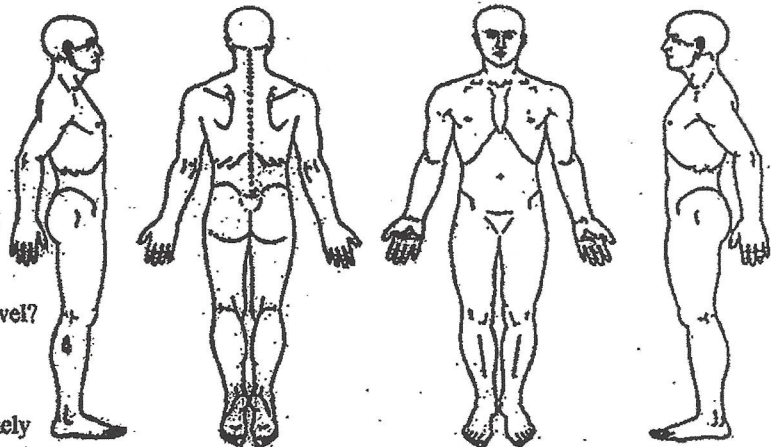
Who have you seen in the past for the same or similar condition.
This office other chiropractor medical doctor physical therapist
other _____

What is your occupation? _____
Full time Part time Self-employed Unemployed Other

In general, how would you describe your overall health?
Excellent Very good Good Fair Poor

What type of regular exercise do you perform?
None Light Moderate Strenuous
How many times per week? _____

What is your height? _____ ft. _____ in. your weight? _____ lbs.



Please list all prescriptions, medications, or supplements that you are currently taking:

Please list all surgical procedures and any hospitalizations:

Please indicate if an immediate family member has any of the following:

____ Rheumatoid Arthritis
____ Heart Problems
____ Diabetes
____ Cancer
____ Lupus
____ other _____

Liberty Chiropractic Center

Patient Health Questionnaire – 2

Patient Name _____ Date _____

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	_____	_____	High Blood Pressure	_____	_____	Diabetes
_____	_____	Neck Pain	_____	_____	Heart Attack	_____	_____	Excessive Thirst
_____	_____	Upper Back Pain	_____	_____	Chest Pain	_____	_____	Frequent Urination
_____	_____	Mid Back Pain	_____	_____	Stroke			
_____	_____	Low Back Pain	_____	_____	Angina	_____	_____	Smoking/Tobacco Use
						_____	_____	Drug/Alcohol Dependence
_____	_____	Shoulder Pain	_____	_____	Kidney Stones			Allergies
_____	_____	Elbow/Upper Arm Pain	_____	_____	Kidney Disorders	_____	_____	Depression
_____	_____	Wrist Pain	_____	_____	Bladder Infection	_____	_____	Systemic Lupus
_____	_____	Hand Pain	_____	_____	Painful Urination	_____	_____	Epilepsy
					Loss of Bladder Control	_____	_____	Dermatitis/Eczema/Rash
_____	_____	Hip/Upper Leg Pain	_____	_____	Prostate Problems	_____	_____	HIV/AIDS
_____	_____	Knee/Lower Leg Pain						
_____	_____	Ankle/Foot Pain	_____	_____	Abnormal weight gain/loss			
					Loss of appetite			
_____	_____	Jaw Pain	_____	_____	Abdominal Pain			
					Ulcer			
_____	_____	Joint Swelling/Stiffness	_____	_____	Hepatitis			
_____	_____	Arthritis	_____	_____	Liver/Gall Bladder Disorder			
_____	_____	Rheumatoid Arthritis	_____	_____	Cancer			
					Tumor			
_____	_____	General Fatigue	_____	_____	Asthma			
_____	_____	Muscular Incoordination	_____	_____	Chronic Sinusitis			
_____	_____	Visual Disturbances	_____	_____				
_____	_____	Dizziness	_____	_____				

Patient Signature _____ Date _____

Doctor's Additional Comments

Doctors Signature _____ Date _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

**LIBERTY CHIROPRACTIC CENTER
257 W Mill Street, Liberty, Missouri 64068**

Financial Responsibility

I have requested professional services from Liberty Chiropractic Center, (Provider), on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment myself and Provider upon request. On proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me from my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to release information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee healthcare benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any health-care expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient

Date

Policyholder/Insured

Date

Liberty Chiropractic Center
Notice of Privacy Practices Acknowledgement

A Notice of Privacy Practices (NPP) is available for review to all patients. This notice identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to file a complaint if you believe your privacy rights may have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read and understands the Notice of Privacy Practices and is the patient, or the patient's legal representative.

_____ Name of Patient	_____ Signature of Patient	_____ Date Signed
_____ Patient's Legal Representative	_____ Signature of Legal Representative	_____ Date Signed

FOR INTERNAL USE ONLY

_____ Name of Employee	_____ Signature of Employee
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If applicable, reason patient's written acknowledgement could not be obtained:

Patient was unable to sign ____

Patient refused to sign ____

Other _____

Liberty Chiropractic Center

Consent to Treat Minor/Acknowledgment of Financial
Responsibility

I, (your name) _____, the ☐ Mother ☐ Father ☐ Legal Guardian
of (name of Minor) _____ do hereby consent to and allow the
rendering of care, including diagnostic procedures and treatment given by
Dr. Phillip Chapman at Liberty Chiropractic Center upon the Minor named above.

I acknowledge that I am responsible for any balance on the Minor's account
(whether on a self-pay basis, or after insurance processing – whichever I elect) in
connection with treatment rendered unto the Minor throughout the course of
his/her care.

I have read this form and certify that I understand its contents. I understand
that I must notify Liberty Chiropractic Center in writing to make any modifications
to this form.

Signature (Mother, Father or Guardian): _____

Date: ____ / ____ / ____

Phone (in case of emergency): (____) _____ - _____

Address of Guarantor (for billing purposes):

Home/Apt. #/ Street: _____ City: _____

State: _____ Zip: _____