HEALING WELL CHIROPRACTIC
The path to being well, living well...

125 NE 91st Street
Kansas City, MO 64155
816.436.7500
Website: www.HWCKC.com
E-Mail: info@hwckc.com

PATIENT INFORMATION

WELCOME! Please allow our staff to photocopy your driver's license and all available insurance cards. PLEASE PRINT.

Full Name _____ **Home Phone** _____ **Cell Phone** _____

Preferred Name/Nickname: _____

Address _____**City** _____ **State** _____ **Zip** _____

Age _____ **Birthday** _____ **Gender:** M F **Marital Status:** S M W D Sep **No. Children** _____

Email_____ **SS#**_____ **Driver's License#** _____

Your Employer _____ **Your Occupation** _____ **Years on Job** _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____ Do ***you*** have health insurance at work? ☐ Yes ☐ No

Insurance Company_____ Plan/Group# _____ Cert#_____

Name of Spouse, Parent or Guardian _____Age ____ Birth Date _____ SS#_____

Spouse's Employer _____ Spouse's Occupation _____Years on Job _____

Employer Address _____City _____ State _____Zip_____

Work Phone_____ Does ***your spouse*** have health insurance at work? ☐ Yes ☐ No

Insurance Company_____ Plan/Group# _____Cert#_____

How did you find out about our office? _____

Referring Doctor_____ Friend_____ Address_____

Reason for your visit today? (Please list areas of pain): _____

Name of Emergency contact or nearest relative not living with you: _____

Is your condition due to an accident? Yes No Date of your accident: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care pan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature_____ Date _____

Spouse's or Guardian's Signature _____ Date _____

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TODDLER HEALTH SURVEY (THREE TO FIVE YEARS)

Patient Name_____ Age_____ Date_____

Reason for seeking chiropractic evaluation: _____

_____

Please indicate if your child has or ever had any of the following:

Back or neck pain	Y N	Pain in legs or arms	Y N
Torticollis (severe head tilt)	Y N	Headaches	Y N
Ear infections	Y N	Tubes in the ears	Y N
Has frequent colds, cough or runny nose	Y N	Had colic as an infant	Y N
Asthma	Y N	Allergies*	Y N
Eating difficulties	Y N	Constipation	Y N
Diarrhea, upset stomach	Y N	Bed wetting	Y N
Skin problems (eczema, rashes, etc.)	Y N	Childhood diseases	Y N

**If child does have allergies, please list below:*

_____

_____

_____

Trauma

Fall from a bicycle, scooter, skate board, etc.	Y N	Fall down the stairs	Y N
Fall from a significant height	Y N	Motor vehicle accident	Y N
Injuries (bone fracture, burn, cut, etc.)	Y N	Planned C-section	Y N
Trips and falls easily	Y N		

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Emotional Status

*Please check if your child has or ever had any of the following***:**

Sleeping difficulties	Y N	Cries a lot	Y N
Has frequent temper tantrums	Y N	Shy	Y N
Separation Anxiety	Y N	Afraid of new environment	Y N

Family History

*Does any one in the child's family have***:**

Asthma	Y N	Respiratory allergies	Y N
Food allergies	Y N	Takes vitamin supplements	Y N

Nutrition:

Please check if your child has received any of the following:

Breast Milk: _____ How long? _____

Formula (*please indicate the brand)*: _____

Cow's Milk (*please indicate the brand)*: _____

Soy Milk (*please indicate the brand)*: _____

Fruit Juices *(please indicate the brand)*: _____

Vegetable Juices *(please indicate the brand)*: _____

At what age was solid food introduced? _____ What was introduced first? _____

The child is a good eater	Y N	Likes a variety of foods	Y N
Has food allergies*	Y N	Takes vitamin supplements	Y N

**If child does have food allergies, please list below:*

_____

_____

_____

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Immunization Status:

☐ **Choosing not to immunize** ☐**All up to date and current**

List the immunizations your child has received and any reaction you have observed:

Date	Immunization	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Health Care:

Name of Pediatrician: _____Name of Chiropractor: _____

Date of Last Exam: _____

Is your child under medical care for a specific condition? If so, please list the condition and the care received:

_____

_____

Do you have any concerns about your child's health? _____

_____

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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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.

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.

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.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

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.

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.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

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.

Identification of Persons with
Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Healing Well Chiropractic include but may not be limited to:

The staff of Healing Well Chiropractic. This includes:
_x_Dr. Strouf_____
_x_All Chiropractic Assistants_____

Necessary health care providers or family members who may need to be consulted if related to the patient's condition. This includes:
_____
_____
_x__Your primary care physician Name:_____
Address:_____
City:_____State:_____ Zip:_____
Phone:_____ Fax:_____
E-mail:_____

_____ _____
Patient Signature Date

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INFORMED CONSENT CHIROPRACTIC CARE

In coming to Dr. Strouf you give the doctors permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Dr. Strouf of course, will not give any treatment or health care if he/she is aware that such care may be contra-indicated.

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 not come to the attention of the doctor. Dr. Strouf provide a specialized, non-duplicating health care service. Dr. Kristine M. Strouf are licensed in Chiropractic and are available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by Dr. Strouf at Healing Well Chiropractic, I am authorizing her to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Initial_____

Photo/Announcement Release:

I, PATIENT NAME: (Please Print)_____ , give Healing Well Chiropractic, LLC permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial_____

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge at this time for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Initial _____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**