Patient Information Packet

Today's Date: _____

PATIENT INFORMATION:

Name:(Last, First MI) _____ **Preferred Name**: _____

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

Home: _____ **Mobile:** _____ **Work: _____**

May we text appointment reminders? _____Yes _____No

May we send you emails on events and special promotions? _____Yes _____ No **Email:** _____

Date of Birth:_____ **Gender:** M / F

***Referred By**: _____

Have you had Acupuncture before _____YES ____NO
Have you ever had a Chiropractic Service before ____YES ____NO

EMERGENCY CONTACT INFORMATION

Full Name: _____

Home:_____ Mobile: _____

Relationship: Child / Parent / Spouse / Other:

_____

FINANCIAL INFORMATION:

(a) Insurance **(b)** Worker's Comp **(c)** Self-Pay (Cash) **(d)** Personal Injury/Auto **(e)** Other_____
(please explain)

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications:

Allergies to Medications: NONE (List)_____

_____

_____

Current Medications: NONE (Already have a list? We can make a copy.)

_____

_____

Major Injuries/Traumas: NONE _____

Diagnosed Medical Conditions: None_____

Wellness Concepts Clinic, LLC

Patient Case History

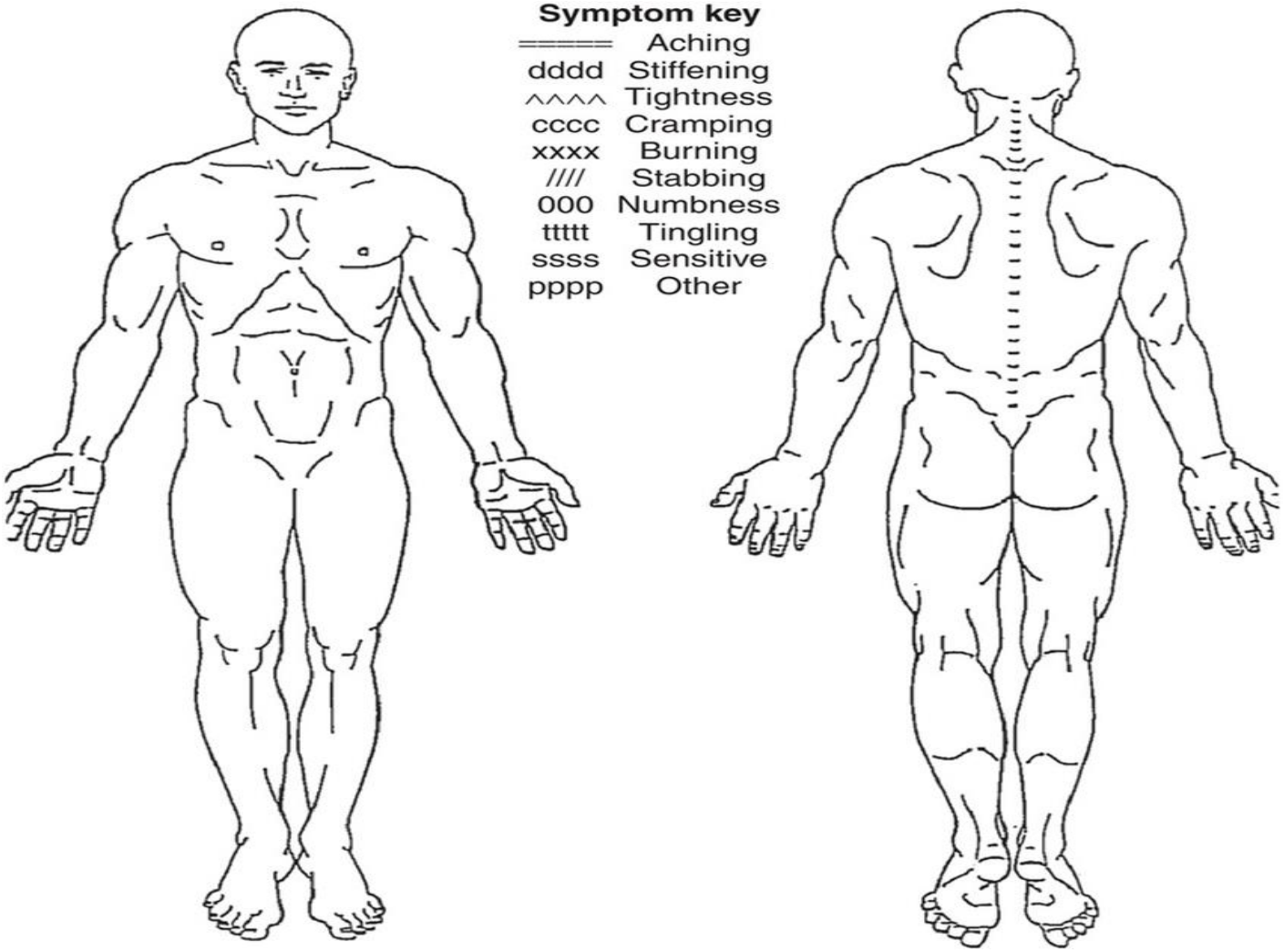
HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When?_____ /_____ /_____ **Describe how this began:** _____

_____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe



For this CURRENT condition, have you:

Received any other treatment? None / DC / MD / PT / Massage / ER / Other:_____ Where?_____

Had any previous Surgery or Interventions in this area? (Describe)_____
Taken any Medications? OTC / Prescriptions **Had any diagnostic testing?** X-rays / MRI / CT / Other:
When_____ and Where?_____

Informed Consent for Chiropractic &/or Acupuncture Treatment:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by Wellness Concepts Clinic and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. In the practice of acupuncture there are some risks to treatment, including but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, and stuck or bent needles. Acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature: (parent if minor) _____ **Date:** _____

Print Name:_____

Wellness Concepts Clinic 1200 E. Woodhurst Dr. R300 Springfield, MO, 65804 (417) 877-1300 Fax (417) 877-1335

HIPAA Notice:

I understand and agree to allow Wellness Concepts Clinic to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules. You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

_____ _____

Patient Signature Authorized provider representative

_____ _____

Personal representative Printed Personal representative signature