Wellness Concepts Clinic, LLC

Today's Date_____

Name (Last, First, MI):_____Preferred Name:_____
Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell:_____Work:_____Work Extension:_____
Email(optional):_____May we send you emails on events and special promotions?__Yes__No
Date of Birth:_____ Gender: M / F Referred By:_____
Have you had Acupuncture, Chiropractic Adjustments, Biofeedback or Massage before? _____Yes_____No
Emergency Contact Information:
Name:_____Number:_____Relationship: Child/Parent/Spouse/ Other:_____
How did you hear about us?_____

Please fill in the information requested below.
All information will be kept confidential and may be used for collection of data for research purposes..

How did you hear about us? _____
Do you have, or have you ever had, any of the following?

NO	YES/WHEN?	
___	_____	Allergies (What kind?) _____
___	_____	Arthritis
___	_____	Back Problems ___Upper ___Middle ___Lower
___	_____	Cancer (What kind?) _____
___	_____	Diabetes
___	_____	Dislocations/Fractures (Where? What kind?) _____
___	_____	Edema
___	_____	Gout
___	_____	Headaches
___	_____	★ Heart Problems (What kind?) _____
___	_____	Hepatitis
___	_____	Hernia (What kind?) _____
___	_____	★ High Blood Pressure ___Controlled by medicine
___	_____	Hypoglycemia (Low blood sugar)
___	_____	★ Kidney Disease
___	_____	Low Blood Pressure
___	_____	Neurological Diseases ___M.S. ___Parkinson's ___Other _____
___	_____	Muscle Cramping
___	_____	Neck Problems (What kind?) _____
___	_____	Osteoporosis
___	_____	Skin Problems ___Rashes ___Eczema ___Psoriasis ___Other _____
___	_____	Stomach Problems (What kind?) _____
___	_____	Surgery (Where? What kind?) _____
___	_____	TMJD
___	_____	Varicose Veins (Where?)_____
___	_____	Recent Injuries or accidents ___Motor Vehicle ___X-rays taken
___	_____	Areas of numbness, weakness, or shooting pains in arms or legs
___	_____	Contagious Diseases? ___Herpes ___AIDS ____Other _____
___	_____	Are you pregnant? (How many months?)_____
___	_____	Other health problems or things you would like us to know about you?

_____

★
This request for information does not imply, in any way, the practice of medicine or diagnosis of a client's condition. Wellness Concepts Clinic, LLC reserves the right to restrict service to, or decline acceptance of, the client.

This is to certify that I am requesting services on my own initiative and I realize that WCC CAM, does not diagnose ailments or prescribe. We do make health recommendations. I release WCC CAM, LLC from any liability for claims resulting from the use of it's services.

SIGNATURE _____ Date_____

(417) 877-1300 Fax (417) 877-1335

Wellness Concepts Clinic, LLC

Patient Case History

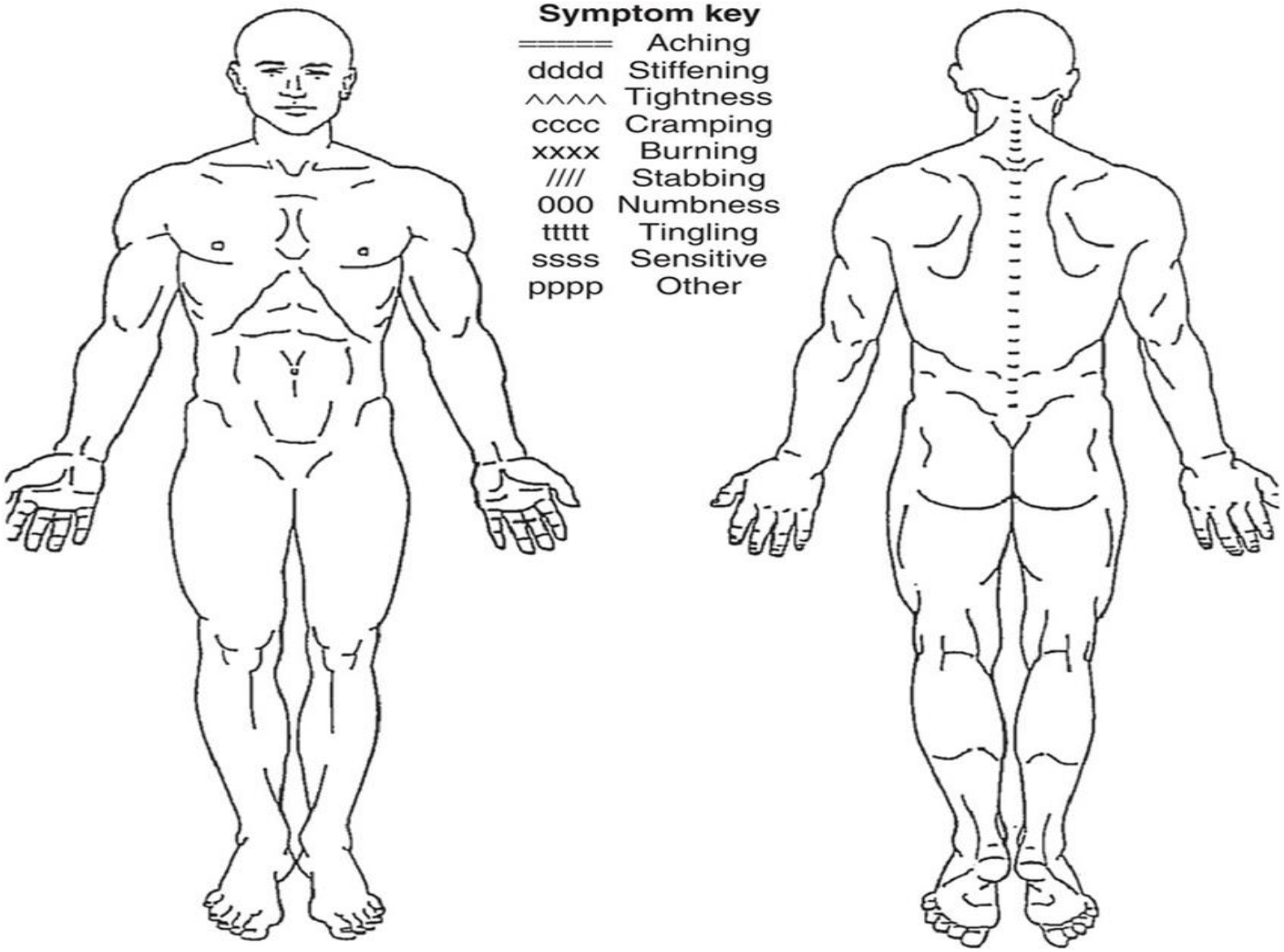
HISTORY OF CURRENT CONDITION

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?_____

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Wellness Concepts Clinic, LLC

Informed Consent for Chiropractic, Acupuncture, Biofeedback, Massage or Foot Detox 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.

Neither Biofeedback professionals nor Biofeedback devices are intended to diagnose, treat, cure or prevent any medical or psychological condition, disease or disorder. We are not medical doctors, DC or psychotherapists. We are a Biofeedback professional and practice Biofeedback training according to the laws of the state of which we are practicing. We train people with Biofeedback to manage their stress and pain through relaxation and to become aware of lifestyle changes to enhance a positive state of health.

We also utilize other CAM modalities including:

Medical Massage, Electromedicine Modalities (PEMF, CES, Auriculotherapy, Foot Detox, Light Technology), Medical Intuition Sessions, Aromatherapy, Homeopathy, Nutritional Supplementations, Acupuncture, Chiropractic and Chinese Medicine principles/herbs.

This request for information does not imply, in any way, the practice of medicine or diagnosis of a client's condition. Wellness Concepts Clinic, LLC reserves the right to restrict service to, or decline acceptance of, the client.

This is to certify that I am requesting services on my own initiative and I realize that the practitioners of Biofeedback, Massage and other Integrative Services with Wellness Concepts Clinic, LLC and CAM, does not diagnose ailments or prescribe. We do make health care recommendations. I release Wellness Concepts Clinic, LLC and CAM from any liability for claims resulting from the use of these services.

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

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Financial Policy

Office Financial Policy and Authorization to Bill Insurance

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immedicably and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____**Private Self Pay** (you will be responsible for payment of all services at the time of service) Private Pay patients are patients that do not bill insurance. This discounted cash rate is only applied to the published rate if you pay at the time of service.

_____**Insurance Billing** (Medical or Auto Insurance)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check out for today's visit, and every visit hereafter. Wellness Concepts Clinic will submit my claim for me to my insurance company. Although Wellness Concepts Clinic verifies my insurance; I understand that this verification is not a guarantee of payment. I understand that all charges incurred at this office including co-payment, co-insurance, percentage and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. I further understand that any unpaid balance over 90 days can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Wellness Concepts Clinic. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time, no other records shall be release without my consent.

_____ _____

Signature of Responsible Party Date

_____

Printed Name

_____ _____

Signature of Responsible Party Date

_____

Printed Name

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HIPPA Privacy Act Patient Consent Form The Health Insurance Portability and Protection Act, H.I.P.P.A requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe. Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent**.**

Name of Patient: _____ Patient Date of Birth _____

Signature of Patient or Guardian: _____ Date _____

Authorization to Release Information to Family Members and/or Friends Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits, and/or the request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. This H.I.P.P.A consent is valid up to one year. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures.

1. Individual Name_____ Relation to Patient: _____

2. Individual Name_____ Relation to Patient: _____

Signature of Patient or Guardian: _____ Date _____

Leaving Messages with Household Members/Answering Machine From time to time it is necessary for our office to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to go over insurance benefits, to notify the patient that we would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

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