In Touch Chiropractic P.C.
1611 N State Rte 7
Pleasant Hill , MO 64080
p 816.540.7926

intouch.medicfusion.com

Patient: _____

Patient Profile

Personal Information

Full Name: _____ Jr / Sr
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Birth Date: ___/___/___

Social Security Number #: ___-___-___

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Time Zone: _____

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) _____

In Touch Chiropractic P.C.
1611 N State Rte 7
Pleasant Hill , MO 64080
p 816.540.7926

intouch.medicfusion.com

Physician Form

Physician Information

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. Fax: _____

Email Address: _____

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. Fax: _____

Email Address: _____

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. Fax: _____

Email Address: _____

In Touch Chiropractic P.C.
1611 N State Rte 7
Pleasant Hill , MO 64080
p 816.540.7926

intouch.medicfusion.com

Employer Form

Employer Information

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. Fax: _____

Start Date: / / End Date: (If you are no longer working here.) / /

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. Fax: _____

Start Date: / / End Date: (If you are no longer working here.) / /

In Touch Chiropractic P.C.
1611 N State Rte 7
Pleasant Hill , MO 64080
p 816.540.7926

intouch.medicfusion.com

Responsible Party Form

Responsible Party Information

Relationship to You: _____

Full Name: _____
First *M.I.* *Last*

Same as your address? ☐ Yes ☐ No

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

In Touch Chiropractic P.C.
1611 N State Rte 7
Pleasant Hill , MO 64080
p 816.540.7926

intouch.medicfusion.com

Patient: _____

Authorizations and Releases

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Initial _____

Signature _____ Date _____

In Touch Chiropractic P.C.
1611 N State Rte 7
Pleasant Hill , MO 64080
p 816.540.7926

intouch.medicfusion.com

Patient: _____

Chief Complaint Form

Chief Complaint

Case Title: _____

Describe the reason for your visit: _____

_____

_____

When did your symptoms begin? (select one)

☐ Today ☐ This week ☐ Within last 3 months

☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: ____/____/____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night

☐ It changes with the weather ☐ It does not change

What helps *relieve* your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) _____

What activities are limited by your discomfort? (select one or more)

☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine

☐ Driving ☐ Getting Up ☐ Lifting ☐ Lying Down

☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting

☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning my head

☐ Urination ☐ Walking ☐ Working ☐ Other (please describe) _____

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: ____/____ Dental X-rays: ____/____

Spinal X-ray: ____/____ CT Scan: ____/____

MRI: ____/____ Other Scans or X-rays: ____/____

In Touch Chiropractic P.C.
1611 N State Rte 7
Pleasant Hill , MO 64080
p 816.540.7926

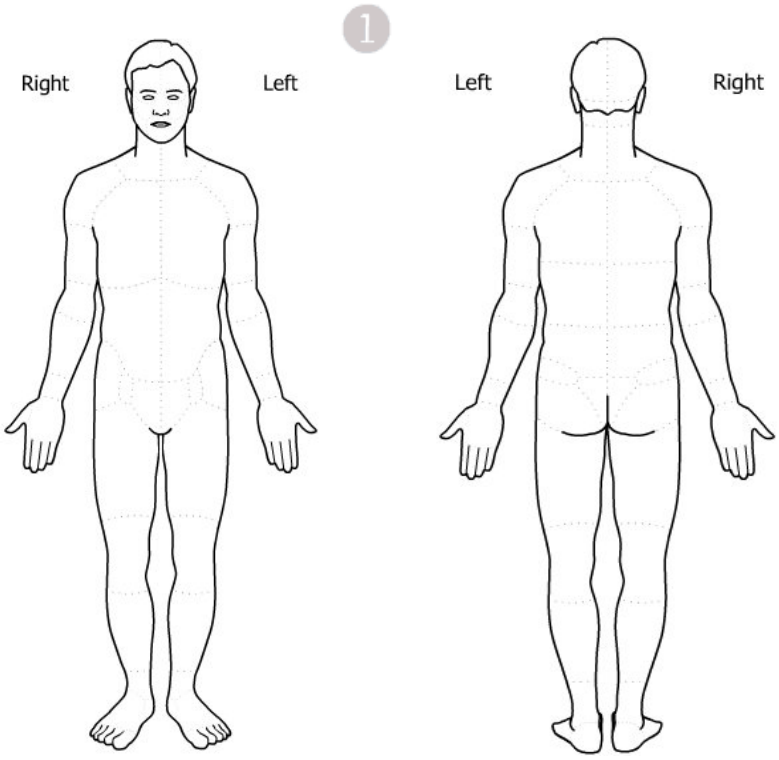
intouch.medicfusion.com

Patient: _____

Patient Symptom Illustrator

Patient Symptom Illustrator

Front **Back**



Instructions:

1. Identify your areas of discomfort by marking the affected body parts in the illustration.

2. Indicate the area name along with your specific symptoms associated with each selected area.

3. Rate your discomfort associated with each selected area.

	2	Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	3 0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 X 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10