

BATEMAN – GATROST CHIROPRACTIC, P.C.

19501-B East 40 Highway; Independence, MO 64055

Phone: 816 / 795-5000 Fax: 816 / 795-5001

L. Wayne Bateman, D.C. Carlos A. Bateman, D.C. Albert L. Gatrost, D.C. Syrece K. Sherman, D.C.

Date: _____ Account # _____ Doctor: LWB ALG CAB SKS

*First Name _____ Nick Name _____

*Last Name _____ Middle Name _____ Suffix _____

Address _____

City _____ State _____ *Zip Code _____

Primary Phone _____ Mobile Phone _____

Secondary Phone _____ Email _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

*Date of Birth Age _____ SSN _____ - _____ - _____

*Gender (check one) Male Female Unspecified Marital Status (check one) Single Married Other

Spouse/Parent/Legal Guardian Name _____ Phone _____

Employment Status:(check one) Employed FT Student PT Student Other Retired Self Employed

*Occupation: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Race (check one)

White Black/African American American Indian/Alaskan Native Asian
 Native Hawaiian or other Pacific Island Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Japanese French Creole Greek Hindi
 Persian Urdu Gujarati Armenian I choose not to specify

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

No interest 0 1 2 3 4 5 6 7 8 9 10 Very Interested

***Current Medications Prescribed by a doctor:** If there are no current medications, check here:

Does your primary medical doctor have you on an Aspirin regimen? Yes No

Medication: _____ Dosage: _____ Generic Brand Name Unknown

Start Date: _____ Current condition patient is taking medication for? _____

Medication: _____ Dosage: _____ Generic Brand Name Unknown

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Medication: _____ Dosage: _____ Generic Brand Name Unknown

Start Date: _____ Current condition patient is taking medication for? _____

***List any known allergies you have had to any medications. - If no allergies are known, check here:**

1) _____ 3) _____
2) _____ 4) _____

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

Primary Care Physician

*Provider Name _____ Provider Phone/Fax: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: ____/____/____ Chart # _____

To be performed by clinic staff: Ht: _____ in Wt: _____ lbs
BP: _____ / _____ Heart Rate: _____ bpm O2 _____ Temp _____ Resp/min _____

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Doctor: LWB ALG CAB SKS

Patient Name: _____

Account # _____

Reason for Visit

Problem Areas:

*Describe your problem(s): _____

*On a Scale of 0-10, rate the intensity: Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest

*How did your problem begin: _____

*Onset date of problem: _____

How often do you experience symptoms: _____

What is the nature of your symptoms (mark all that apply): Dull Sharp Throbbing Burning Deep Aching
 Tingling Stabbing Cramping Numbness Radiating

Does it affect other areas of your body: Yes No

To what areas does the pain radiate, shoot, travel: _____

What makes the problem worse? (time of day, movements, activities): _____

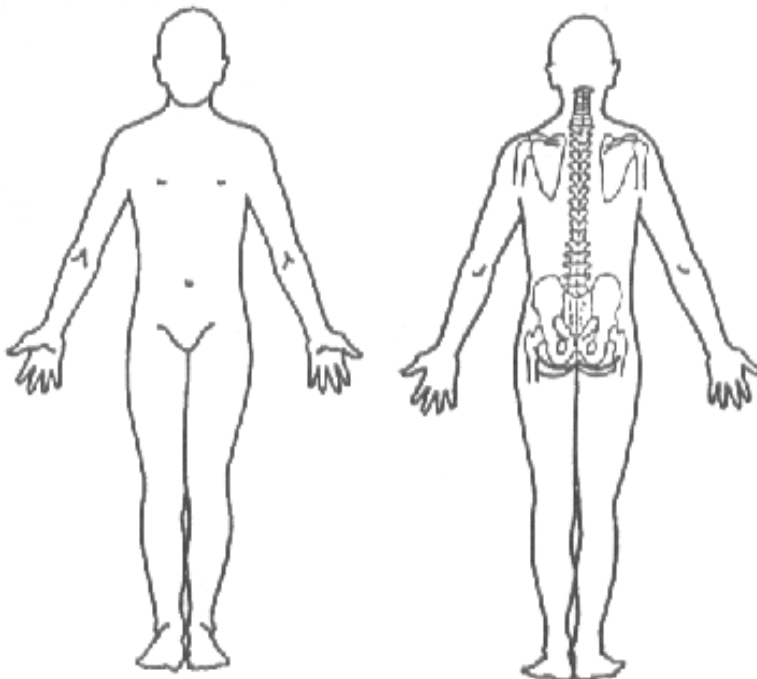
What have you done to relieve the Symptoms? Prescription Medications Over the counter drugs
 Homeopathic remedies Physical Therapy Surgery
 Acupuncture Chiropractic Ice Heat
 Other: _____

*What should we know about your current condition: _____

Pain Chart

0 = No pain / 5 = Medium pain / 10 = Severe pain

Circle areas of discomfort on figures



Neck-Shoulder-Arm Pain

On a scale of 0-10, I rate my discomfort as follows:
Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest

Mid-Back Pain

On a scale of 0-10, I rate my discomfort as follows:
Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest

Low-Back and Leg Pain

On a scale of 0-10, I rate my discomfort as follows:
Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest

Medical History

Illnesses:

Illness: _____ Start date: _____ End date: _____
 Illness: _____ Start date: _____ End date: _____
 Illness: _____ Start date: _____ End date: _____

Surgeries:

Surgery: _____ Date: _____
 Surgery: _____ Date: _____

Hospitalizations:

Reason: _____ Date: _____ Duration: _____
 Reason: _____ Date: _____ Duration: _____
 Reason: _____ Date: _____ Duration: _____

Injuries:

Injury: _____ Date _____
 Injury: _____ Date _____
 Injury: _____ Date _____

Have you seen a Chiropractor before? Yes No If yes, list name of doctor and date(s): _____

Did the treatment received help your condition? Yes No

What condition were you treated for? _____

How long were you treated? _____

Family History

Please review the diseases and conditions listed below and indicate the type of disease that are current health problems of the family member listed. Leave those spaces blank that do not apply. Circle your answers if your relatives live around this locality, as some hereditary conditions are affected by similar climate.

CONDITIONS:	FATHER	MOTHER	BROTHER(S)	SISTER(S)	SON(S)	DAUGHTER(S)
Year Born						
Age / Cause of Death						
Cancer (Type)						
Clotting Issue (Type)						
Dementia / Alzheimer's						
Diabetes / Pre-Diabetic						
Gastrointestinal (Type)						
Heart Disease (Type)						
High Cholesterol						
Disc Problems						
Hypertension						
Kidney Disease (Type)						
Lung Disease (Type)						
Osteoporosis						
Psychological (Type)						
Septicemia						
Stroke / Brain Attack						
SIDS						
Arthritis / Gout (Type)						
Bursitis						
Headaches						
Liver Disorder						
Nerve Pain						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Thyroid						
Other:						

Social History

Consumption:

How many ounces of liquid do you consume on a daily basis? ___ Water ___ Coffee ___ Soda ___ Alcohol ___ Other

How much do you depend on pain relievers? _____

Stress/ Sleep Information:

*How much physical stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot

*How much emotional stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot

How many hours do you sleep per night: _____

What is your preferred sleeping position: _____

Healthy Eating and Exercise Information:

How much regular exercise do you perform: _____

*Rate your healthy eating habits: Not healthy – 0 1 2 3 4 5 6 7 8 9 10 – Healthy

Typical eating habits (mark all that apply): ___ Skip breakfast ___ 2 meals per day ___ 3 meals per day

 ___ Snacking between meals

Acknowledgements

Chiropractic care:

- I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Privacy Verification:

- I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Permission to contact:

- I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification:

- I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

X-ray Verification:(females only)

- I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period:

General Verification:

- To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____

Date: _____

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COMMERCIAL ASSIGNMENT OF BENEFITS & RELEASE:

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE AND, IN CONSIDERATION OF SERVICES RENDERED, ASSIGN DIRECTLY TO BATEMAN – GATROST CHIROPRACTIC, P.C. ALL PAYMENTS FROM MEDICAL HEALTH BENEFITS, AND / OR ANY PAYMENTS FROM MY ATTORNEY, THIRD PARTY PAYOR, MEDICAL / PIP COVERAGE, IF ANY, OTHERWISE PAYABLE TO ME. I AUTHORIZE THE RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

PATIENT INITIALS _____

MEDICARE AUTHORIZATION:

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO BATEMAN – GATROST CHIROPRACTIC, P.C. FOR ANY SERVICES FURNISHED TO ME BY SAID PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO BATEMAN – GATROST CHIROPRACTIC, P.C. AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT MEDICARE & MEDICARE ADVANTAGE INSURERS REQUIRE AN EXAM AND NECESSARY X-RAYS; HOWEVER, MEDICARE AND MEDICARE ADVANTAGE INSURERS **DO NOT COVER ANY CHARGES FOR EXAM, X-RAY, OR THERAPY.** MEDICARE & MEDICARE ADVANTAGE INSURERS COVER **SPINAL ADJUSTMENTS ONLY.**

PATIENT INITIALS _____

AUTHORIZATION TO DISCLOSE INFORMATION:

I, THE UNDERSIGNED, HERE BY AUTHORIZE BATEMAN-GATROST CHIROPRACTIC TO RELEASE ANY AND ALL INFORMATION REGARDING MY CONDITION, TREATMENT, AND FINANCIAL STATUS AS IT RELATES TO MY CASE TO THE FOLLOWING:

- 1.) _____ PHONE #: _____
- 2.) _____ PHONE #: _____
- 3.) _____ PHONE #: _____

PATIENT FINANCIAL AGREEMENT:

I, THE UNDERSIGNED, AGREE TO PAY FOR THE BALANCE OF MY ACCOUNT. ALTHOUGH AN INSURANCE CLAIM (IF APPLICABLE) WILL BE FILED WITH MY INSURANCE COMPANY ON MY BEHALF, NEGOTIATING PAYMENT THROUGH MY INSURANCE COMPANY ULTIMATELY IS MY OBLIGATION. IF I HAVE NO INSURANCE, I AGREE THAT PAYMENT WILL BE MADE AT THE TIME SERVICES ARE RENDERED UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE **PRIOR** TO THE SERVICES. A STATEMENT WILL BE MAILED MONTHLY SHOWING ANY BALANCE DUE FROM ME AND IS CONSIDERED PAST DUE WITHIN 30 DAYS FROM RECEIPT. IF I DO NOT RECEIVE A STATEMENT WITHIN 45 DAYS OF MY VISIT, IT IS MY RESPONSIBILITY TO CONTACT BATEMAN – GATROST CHIROPRACTIC, P.C. TO VERIFY MY CURRENT ADDRESS AND ANY BALANCE DUE. IF I AM UNABLE TO MAKE PAYMENT IN FULL, I SHOULD CALL THE BILLING DEPARTMENT IMMEDIATELY TO MAKE PAYMENT ARRANGEMENTS.

I UNDERSTAND THAT ITEMS BILLED TO INSURANCE BECOME PAST DUE IF NO REPLY IS RECEIVED WITHIN 45 DAYS. I UNDERSTAND THAT IF NO PAYMENT HAS BEEN RECEIVED OR FINANCIAL ARRANGEMENTS MADE ON MY BALANCE AFTER 45 DAYS, MY ACCOUNT MAY BE REFERRED FOR COLLECTION. IF REFERRED FOR COLLECTION, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE BALANCE AS WELL AS ANY FEES INVOLVED IN THE COLLECTION PROCESS.

TREATMENT TIME IS VALUABLE, **IF YOU CANNOT KEEP YOUR APPOINTMENT PLEASE CALL**; OTHERS MAY NEED CARE. IT IS THE GOAL OF BATEMAN-GATROST CHIROPRACTIC, P.C. TO ALWAYS PROVIDE THE BEST STANDARD OF CARE POSSIBLE. STRICT ADHERENCE TO THE PRESCRIBED TREATMENT PLAN WILL MAXIMIZE THE OUTCOME OF CARE.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE CURRENT IDENTIFICATION VERIFICATION AND INSURANCE CARD AT CHECK IN. TIME OF SERVICE CHARGE IS PROVIDED AND PAYMENT IN FULL IS REQUIRED THE SAME DAY OF SERVICE.

Patient Name – please print

Date

Patient Signature/Parent or Legal Guardian if minor

Relationship to Patient

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____

Date of Birth: _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Bateman-Gatrost Chiropractic P.C..

I understand that the Notice describes the uses and disclosures of my protected health information by Bateman-Gatrost Chiropractic P.C. and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement
- Communications barriers prohibited obtaining the acknowledgement
- Other (please specify): _____

Employee Name

Today's Date

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Please provide us with your email address to start managing your health care from the web.

Name: _____ DOB: ____ / ____ / ____

Email Address:

Verification Question (*choose only one question by marking the question, then give the answer to that question*)

- What is the name of your favorite pet?
- In what city were you born?
- What is your favorite movie?
- What is your mother's maiden name?
- On what street did you grow up?
- What was the make of your first car?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

We are collecting your email address for our records and will use it to issue you an invitation to access your treatment summaries via our secure Patient Portal. We also hope to send appointment reminders via email and to provide you more online communication with our office in the future. We will not disclose your email address to others without your prior written consent and it will not be used for any solicitations.