Dr. Kathy Pansegrau, DC
6402 Westwind Way, Suite 5
Crestwood, KY 40014
502-241-8939
www.360dc.net

360° CHIROPRACTIC
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HEALTH INFORMATION AND HEALTH HISTORY

Patient Name: _____ Gender: (Circle one) Male/Female

Marital Status: M S D W Other:_____ Date of Birth: ____/____/_____

Spouse Name: _____ Number of Children: _____

Patient Social Security Number: _____-_____-_____

Spouse Social Security Number: _____-_____-_____

Patient Address: _____ City:_____ Zip Code: _____

Patient Phone Number: _____-_____-_____ Cellular Number: _____-_____-_____

E-mail Address: _____ Employer: _____

Occupation: _____ Referred By: _____

Is this condition due to: Auto Accident Personal Injury Work Related Accident

Do you have health insurance? Yes No

Name of Insurance Company: _____ ID# _____

Is your spouse employed? Yes No

Is your spouse the primary insured? Yes No If yes, please give DOB ___-___-____

Are you covered by Medicare? Yes No

How would you like to be contacted for appointment reminders? Text Message Email Phone Call

If by text please indicate your carrier for our reminder service: _____

I authorize 360 Degree Chiropractic Center to release medical information to my insurance company:

Signature: _____ Date: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

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HEALTH INFORMATION AND HEALTH HISTORY

COMPLAINTS

Primary Complaint? _____

Secondary Complaint? _____

When did your problem begin? _____

How did your problem begin? _____

Is this problem interfering with your: (circle all the apply please)

Activities of daily living Work Social Activities Hobbies Sleep

Rate your pain: (circle one) 0 being no pain or 10 being the worst pain 0 1 2 3 4 5 6 7 8 9 10

Is your health problem worse: Morning Day Evening Night

Does your health problem occur: Occasionally Intermittently Constantly Frequently

Have you had this problem before? _____ When? _____

What aggravates your health problem: Coughing Sneezing Walking Reaching

Lifting Bending Sitting Lying Down Standing Neck Movement

Straining at stool Other_____

What relieves your health problem: (circle all that apply please) Nothing Resting

Sitting Standing Heat Ice Others _____

Have you had recent treatment for this condition? Yes No

If so, who did you see? _____ Treatment _____Have you had any changes in bowel or bladder habits since your problem began? Yes No

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HEALTH INFORMATION AND HEALTH HISTORY

List your hobbies: 1._____ 2. _____ 3. _____

What are your habits?			
	Smoking	never	packs per day _____
	Alcohol	never	drinks per day _____
	Caffeinated drinks	never	drinks per day _____
	Exercise	never	times per week _____
	Drug/Substance Abuse	never	yes__ if yes discuss with your doctor

Medical History

Have you seen a doctor of chiropractic? Yes No

Who is your Family Physician: _____Date of last physical exam: _____

Do you give us permission to send your family doctor your progress and treatment notes? Yes No

Have you been hospitalized in the past 5 years? Yes No Date and reason, if yes: _____

_____

Have you had any serious accidents in the past 5 years: Yes No Date and Describe, if yes: _____

_____

List your medications: _____

In the past 6 months have you suffered from: Circle all that apply or circle normal please.

General:	Fatigue	Weakness	Weight change	Loss of sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Eyes:	Vision trouble	Dryness	Redness	Cataract/Glaucoma	Normal
Nose:	Pain	Bleeding	Sinus trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged Glands	Tonsillitis	Normal
Cardiovascular:	Coughing Palpitations	Sneezing Hypertension	Wheezing	Chest pain	Normal
Gastrointestinal:	Diarrhea Constipation	Vomiting Gas	Appetite change	Heartburn	Normal
Endocrine:	Goiter	Sugar in urine	Heat intolerance	Cold intolerance	Normal
Psychological:	Anxiety	Depression	Memory loss	Mood swings	Normal

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Have you ever had any of the following: Circle all that apply

Arthritis	Heart Trouble	Pacemaker
Diabetes	Dislocated Joints	Hay Fever
Asthma	Bone Fracture	Tuberculosis
Epilepsy	High Blood Pressure	Serious Injury
Allergies	Low Blood Pressure	Prostate Trouble
Sinus	Rheumatic Fever	Kidney Trouble
Scoliosis	Spinal Disease	Polio
Cancer	Thyroid Trouble	HIV
Ulcer	STD	AIDS

Ladies: Please check any that apply. Taking Birth Control_____ Pregnant_____ Nursing_____

Family History

Has anyone in your family had any of the following: (if yes, list relationship to patient)

Cancer: _____ Diabetes: _____

Heart Trouble: _____ High Blood Pressure: _____

Do any family members suffer from the following: please circle and list the relationship to you
Neck Problems: _____
Back Problems: _____
Headaches: _____
Arthritis: _____
Disc Problems: _____
Pinched Nerves: _____
Bad Posture: _____
Scoliosis: _____
Osteoporosis: _____

Doctor's Signature: _____

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INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for 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. The doctor, of course, will not give any treatment or health care if he 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 is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Health Care Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

_____ _____

Patient Signature Date

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CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. Kathy J. Pansegrau and whomever she may designate as her assistants to perform and administer therapy and treatment as is necessary. I also certify that no guarantee or assurance had been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon request. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment.

_____ _____

Patient Signature Date

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, DEMAND & CERTIFICATION

Insurer and Patient Please Read the Following in its Entirely

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (P.I.P.), Workman's Compensation and General Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this agreement is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payment, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider.

Release of Information: I hereby authorize this provider to: furnish the insurer, an insurer's intermediary and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer request from the insurer all EOB's from all providers and non-redacted PIP payout sheets; obtain copies of all medical records, including but not limited to, documents, records, scans, notes, bills, opinions, X-rays, IME's, and MRI's, from any other medical provider or any insurer. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-reacted PIP payout sheet and the insurance coverage declaration sheet to the above provider with 15 days.

Certification: I certify: that I have not been solicited or promised anything in exchange for receiving health care; that I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment; and that I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you.
If you sign below we will assume you understand and agree to the above.

Patient's Name _____ **Patient's Signature** _____
(Please Print) **(If patient is a minor, signature of parent/guardian)**

Date _____

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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.

1. 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.
2. 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.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. 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.
5. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

_____ _____

Name of Patient Date

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OFFICE FINANCIAL POLICY FOR PATIENT CARE

To help provide the most efficient and reasonable health care service, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete information. The balance due is still your responsibility if we have not received payment from the insurance company within 60 days.

If you have insurance and we file with your carrier, we require payment of balances which are deemed your responsibility (co-payments, deductibles, co-insurance) at the time the service is received. We ask that you please contact your insurance company if your claim has not been paid within 30 days.

If you fail to keep your appointments without notifying us in advance or No Show your scheduled appointment:

1. **The *first* missed appointment is forgiven.**
2. **The *second* missed appointment and any missed appointments thereafter without prior notification you will be charged a $25.00 "no show" fee.**

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payment at the time of service for the entire balance if you are a "Self Pay" patient, or for the amount of any deductible, co-payments or co-insurance. If you are unable to meet your financial obligation, you may be asked to reschedule. If you are a "Self Pay" patient, please see the receptionist for an additional "self pay" policy.
3. Please be prepared to present your insurance card to the receptionist upon signing in. If you cannot provide a copy of your insurance card, you will be considered "Self Pay" and will be required to pay for services in full on the date they are received. Upon receipt of insurance information, and in the event your insurance pays your claim, you will be refunded the amount of the credit due to you at that time.
4. Understand that we, from time to time, may verify insurance benefits on your behalf. Please be aware that we cannot be responsible for misinformation received from your insurance company. Insurance companies have a disclaimer for all callers stating that the benefits given over the phone are only an estimate and that the benefits are not determined until the actual claim is paid. Therefore, it is not possible for us to guarantee any type of coverage or benefit on your behalf.

_____ _____

Patient Signature Date

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described as described below, to those persons listed below.

2. Authorization for release of PHI covering the period of health care (check one)
   a. _____ From (date)_____to (date)_____ OR
   b. _____ All past, present and future periods.

3. I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s)
   Name _____ Relationship_____
   Name _____ Relationship_____
   Name _____ Relationship_____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until nine (9) months after my death or, _____, (date or event) at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and any no longer be protected by federal or state law.

_____ Date:_____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Text

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

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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)