Dr. Karissa D. Rasmussen

GLADSTONE CHIROPRACTIC
SPINE & INJURY CENTER

Account _____

Name: _____

D.O.B.: _____

Date: _____

FOR OFFICE USE ONLY

PLEASE PRINT

Welcome! Thank you for choosing Gladstone Chiropractic as your health care provider. Our trained and caring staff is here to help you achieve maximum benefits from your chiropractic experience. Please allow our staff to photocopy your photo ID and all available insurance cards.

Patient: _____ **[ ] Male [ ] Female**
Last First MI

Address: _____ **Birth date:** _____/_____/_____ **Age:** _____

_____
City State Zip

[ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated **Any Children?:** _____ **#:** _____

Phone Number: _____

Employer: _____ **Occupation:** _____ **Years:**_____

Emergency Contact: _____ **Emergency Phone #:** _____

Contact number where we can leave a message: _____

Email address: _____

How did you hear about us: _____

Date of injury or onset _____

Describe the major complaints that brought you to the office:_____

_____

Background Questionnaire & Past History

Please answer the following questions to help us complete your medical profile:

1. Do you have any medical allergies? ☐Yes (Please list below) ☐No

_____

_____

2. Do you take any prescription or non-prescription medications? ☐Yes (Please list below) ☐No

_____

_____

_____

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3. Please select one of the following options that most closely represents your smoking history:

☐ Never Smoker ☐ Former Smoker ☐Current "some days" smoker ☐Current "every day" smoker

4. Please select your preferred language:

☐ English ☐ Spanish ☐ French ☐German ☐Chinese ☐Italian ☐Other:_____

Family History: Please circle if you or any immediate **family members** have had the following:

Anesthesia problems	Diabetes	Hypertension	Stroke
Heart Attack	Cancer	Depression	Arthritis
Rheumatoid	Gout	Kidney disorder	Bleeding/clotting

Other _____

Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? ☐Yes ☐No

Please list car accident, work or other injuries that required treatment:

_____
_____
_____

List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):

_____ Date: _____
_____ Date: _____
_____ Date: _____

Have you ever been hospitalized for any reason other than surgery? ☐Yes ☐No

Your diet is: ☐Balanced ☐Fair ☐Poor ☐Excessive ☐Restricted

Do you exercise on a regular basis? ☐Yes ☐No Type _____
Do you smoke? ☐Yes ☐No How Long? _____
Do you use? ☐Caffeine ☐Tobacco ☐Nicotine ☐Alcohol ☐Recreational Drugs

Please describe your work. (If retired, describe work prior to retirement)

Type: ☐Physical labor ☐Professional ☐Driver ☐Clerical ☐Factory ☐Homemaker
Physical Demands: ☐Heavy ☐Moderate ☐Mild ☐Sedentary
Stress Level: ☐High ☐Medium ☐Low

_____ _____
Signature of Patient (Signature of Responsible Party, if patient is a minor) Date

7626 North Oak Trafficway Kansas City, MO 64118 816-468-5200 Fax: 816-468-5201 office.gladstonechiropractic@gmail.com
GLADSTONE CHIROPRACTIC

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CASE HISTORY QUESTIONNAIRE

An understanding of your health history will help us to determine appropriate care.
Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

Do you have the following:

Circle all that apply **COMMENTS**

Weight gain/loss, fatigue, insomnia?	_____
Glasses/contacts, cataracts, glaucoma?	_____
Sinus trouble, hearing loss, ringing?	_____
Irregular heartbeat, high blood pressure?	_____
Chest pain, fluttering in chest, coronary artery disease?	_____
Shortness of breath, lung disease, persistent cough?	_____
Decreased appetite, constipation, heartburn?	_____
Nausea, diarrhea, hepatitis A, B, C?	_____
Arthritis, fibromyalgia or osteoporosis?	_____
Kidney stones, bladder or kidney infections?	_____
Prostate problems?	_____
Skin masses, blisters, dermatitis, eczema, psoriasis?	_____
Problems with swallowing?	_____
Seizures, tingling, numbness, severe headaches?	_____
Anxiety, depression, other?	_____
Increased thirst, diabetes, thyroid problems?	_____
Bleeding or clotting problems?	_____
Anemia, swollen or enlarged lymph nodes?	_____
Hay fever, lupus or HIV/AIDS?	

_____

Females:

Is there any chance that you might be pregnant? ☐Yes ☐No

(If you are pregnant or there is a possibility that you are please Notify the X-Ray Technician)

Menstrual problems?	☐ Have Now	☐Yes	☐No
Take birth control pills?	☐ Have Now	☐Yes	☐No
Breast problems?	☐ Have Now	☐Yes	☐No

_____ _____

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Designation of Authorized Representative

I, _____, do hereby designate Karissa D. Rasmussen, D.C. of Gladstone Chiropractic (hereafter referred to as "my doctor"), to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I received from my doctor.

_____ _____

Signature of Patient (Signature of Responsible Party, if patient is a minor) Date

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GLADSTONE CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by Dr. Karissa D. Rasmussen and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Karissa D. Rasmussen, including those working at the clinic or office listed or any other office or clinic.

I have had an opportunity to discuss with Dr. Karissa D. Rasmussen and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

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, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

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.

_____ _____

Signature of Patient (Signature of Responsible Party, if patient is a minor) Date

_____ _____

Witness (Documenting Employee) Date

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Insurance Payment Policies/Fee Disclosure

Code	Procedure	Fee
99201	Brief History/Exam	$100.00
99202	Initial History/Exam	$170.00
99203	Detailed History/Exam	$220.00
99213	Re-evaluation History/Exam	$150.00
99214	Detailed Re-evaluation History/Exam	$230.00
98940	1-2 Level Chiropractic Treatment	$50.00
98941	3-4 Level Chiropractic Treatment	$60.00
72040	Basic Neck X-rays	$105.00
72100	Basic Back X-rays	$105.00
97012	Traction	$35.00
97110	Therapeutic Exercises	$30.00
97140	Manual Therapy	$45.00

All appointments are subject to a $25 fee, if not cancelled or rescheduled two hours prior to appointment time.

- We will attempt to verify your insurance coverage. You are personally responsible for all services received and consent to being billed for non-covered charges.* Possible reasons for non-coverage:

1. The service is or may be deemed investigational or experimental under the carrier's internal guidelines.
2. The service is considered, or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines.
3. The service is not or may not be actually covered under the plan to which the above patient is subscribed.
4. The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.

- If the doctor is a contracted provider for your health plan you are responsible for co-payments at the time of service.
- You authorize our office to release all information necessary to secure benefits. You authorize the use of your signature on any insurance submissions.
- If you have a balance for services, you agree to make a minimum payment of $50 per month or 20%, whichever is greater unless other arrangements are made with our office. **Interest on accounts 60 days past due will be charged a setup fee of $4.00 plus interest at the rate of 12% annually.**

Continued on next page

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- If the doctor is treating you under a lien for injuries sustained in an auto collision, there is an annual $75 administrative fee added to the account in lieu of interest. Regardless of the outcome of the case, all bills will be paid at 100% of the fee schedule.

- We accept cash, checks, debit cards, Visa, MasterCard, American Express, and Discover.

Cash Payment Policies / Fee Disclosure
Fees quoted on request
All fees are payable at Time of Service unless prior arrangements have been authorized.

I have read and fully understand the above financial terms and prices.

Patient Financial Responsibility*:
The undersigned patient acknowledges that the Non-Covered status of the proposed service(s) has been explained, and that a certain portion of the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be, covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay for these services.

Insurance Plan:_____

_____ _____
Signature of Patient (Signature of Responsible Party, if patient is a minor) Date

* **Please note that insurance companies do not guarantee the accuracy of the information they provide to us. You may wish to verify the coverage yourself by calling the number listed on your card.**

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

We must make a good faith effort to obtain a written acknowledgment that we have offered you a copy of our Notice of Privacy Practices no later than the date of first service delivery. If we are unable to obtain your acknowledgment, we must document why.

If there is an emergency, providing our Notice of Privacy Practices may be delayed until reasonably practicable after the emergency situation is resolved.

General referral information & spousal/family information may be shared without compromising the integrity of the patient-doctor privilege, unless specifically requested.

Can we leave messages on an answering machine or voicemail? Yes____No___

Can we leave messages with anyone? Please list whom we can leave a message with below:

Exceptions: _____

Appointment Reminders & Events:

Our office periodically sends out appointment reminders and event announcements.
I do NOT wish to participate in this program. _____(Initial)

PATIENT'S WRITTEN ACKNOWLEDGMENT

I understand a copy of the Notice of Privacy Practices is available for review at any time:

_____
Signature of Patient (Signature of Responsible Party, if patient is a minor)

_____ _____
Printed Name Date

Name of Documenting Employee: _____