WELCOME TO OUR OFFICE!

The following page needs to be completed to assist you with your care. We are unable to accurately calculate the costs involved with your first visit until Dr. Schierling has had the opportunity to discuss your health problems with you. You will, however, be informed of the cost, prior to treatment being rendered. The typical New Patient visit runs between $74.00 to $150.00, depending on what X-rays are taken.

I plan to take care of today's visit by:

___Cash/personal check
___Credit Card (Visa, MasterCard or Discover)

If you are covered by MEDICARE, please present a copy of your card to the front desk.

Insurance Information:

As most of you have experienced, your insurance premiums continue to rise with each policy renewal, your deductibles increase, your co-payments go up, but your benefits continue to go down. The truth behind most PPO or HMO policies is that the physician is under contract to give discounts to your **Insurance Company**. Unfortunately, your insurance company does not pass these discounts on to you.

Although we are considered a Provider for all insurance companies, Schierling Chiropractic, LLC is not a "*Participating*" Provider with any insurance company. There are many reasons for this and it would take a book to write them all down. The bottom line is that it allows us to give discounts to you the patient instead of your insurance company.

We currently give an "at time of service discount" of 33% – 50% on chiropractic services (greater than any insurance company discount) to any and all patients that pay in full on the day of service. Participating Providers are *not* allowed to give patient discounts as it is considered illegal. Patients pay us on the day service is rendered, and we will provide an itemized receipt with all of the information necessary for to be reimbursed. You can then mail/fax this receipt to your insurance carrier if you wish.

On rare occasions; certain patients who have chiropractic coverage, *and* who have met their deductible, may be allowed to assign their benefits to Schierling Chiropractic, LLC and pay the estimated patient portion at the time of service. Please make sure that we have a copy of your current insurance card. **"Time of service discounts" do not *ever* apply to assigned services**. The patient is responsible for any balance not paid by the insurance carrier.

Schierling Chiropractic, LLC reserves the right to add a 53% collection fee to the balance of any account sent to collections. Patients are responsible for any and all legal fees accrued in the process of collecting past due amounts. After 90 days, past due accounts accrue interest at the rate of 18% annually.

I UNDERSTAND THAT IT IS I AND *NOT* MY INSURANCE COMPANY WHO IS RESPONSIBLE FOR ANY BILLS INCURRED AT SCHIERLING CHIROPRACTIC, LLC.

PATIENT SIGNATURE: ___________________________________

Welcome TO SCHIERLING CHIROPRACTIC, LLC

PATIENT INFORMATION: Today's Date: ____________________________

Last Name: ________________________________ First Name: ____________________ Middle Initial: _____

Address: _______________________________________ City: _______________ State: _____ Zip: __________

Date of Birth: ______________________ Social Security #: ________-______-________ Sex: M F

Home Phone #: (_____) __________-______________ Cell Phone #:(_____) _________-________________

E-mail Address: ____________________________________ Driver's License #: _________________________

Employer: ______________________________________ Occupation: _________________________________

Employer Address (Street, City, State, Zip):____

Work Phone #: (_____)_______-______________ Family Physician: ______________________________________

Marital Status: __Married __Single __Widowed __Divorced __Separated Spouse name:_________________

Number of Children: ___ Ages: _________________________

Emergency Contact: _________________________ Phone: ____

How did you hear about us? ___Referral, Who?__________ __Advertising __Website __Other_______________

DISCLOSURE, AUTHORIZATION AND CONSENT TO TREAT:

3. **CHIROPRACTIC ADJUSTMENTS / SPINAL DECOMPRESSION THERAPY**: I consent to all necessary examinations, procedures and / or treatments prescribed by Dr. Russell Schierling and his assistants, or designees as is necessary in his clinical judgment. As with any procedure or form of treatment, there is a degree of risk when undertaking chiropractic care, including but not limited to post-adjustment soreness, bruises, broken bones, herniated discs, vascular accidents, stroke, paralysis, and even death. While highly unlikely, I also realize that like any other form of therapy, Chiropractic care could potentially ***worsen*** my condition. I understand this and wish to be treated by Dr. Schierling anyway.
4. **TISSUE REMODELING**: I acknowledge and understand that if Scar Tissue Remodeling / Myofacial Release is prescribed by Dr. Russell Schierling it may cause any or all of the following: **pain, swelling, edema, redness, stiffness, soreness** and **bruising**, all of which can range from minor to severe in some cases. While highly unlikely, I also realize that like any other form of therapy, Scar Tissue Remodeling could potentially ***worsen*** my condition or cause the problems listed in the section above. I understand all of this and wish to be treated anyway.

X ____________________________________ ________________________

Patient Signature DATE

PATIENT HISTORY FORM:

Present Complaint(s): ____

____

History of Present Complaint:

When did your problem begin? ________________________________

How did your pain begin?________________________________

☐ Immediately after a specific event? ☐ Multiple events?

☐ Gradually developed? ☐ No apparent reason?

Briefly describe injury details:____

Is your pain: ☐ Constant? ☐ Intermittent?

Is your pain: ☐ Improving? ☐ Worsening? ☐ Not changed?

Have you had a similar problem before? ☐☐ Yes ☐ No

If yes, please describe: ____

Is there anything that decreases your pain? ______________What increases your pain? ______________

What level would you rate your problem right now? **None** 0 1 2 3 4 5 6 7 8 9 10 **Most severe**

Is there anything else you feel might be related to this problem?______________________________

Prior tests: X-ray MRI CT Ultrasound Lab Other:______________________

Prior treatment for this problem?

☐ None ☐ Physical therapy ☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Injections ☐ Surgery

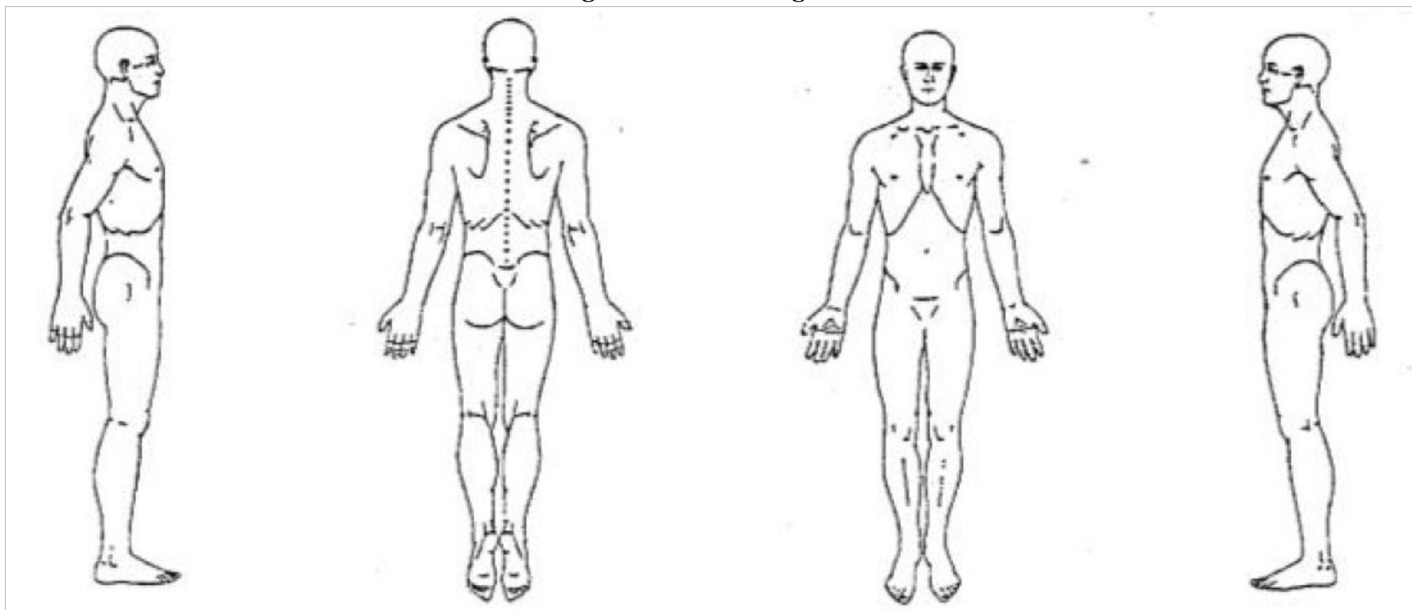
Medications (frequency/dosage) ____________________ Other ____________________________

What have you been told is wrong? ____

When was treatment and did it work? ____

Fill out the pain drawing below using the following symbols:

Ache>>>>> ***Numbness***? ? ? ? ***Burning*** XXXX ***Stabbing***///////// ***Pins &Needles***000000



Family Medical History:

☐ Rheumatoid arthritis ☐ Heart disease ☐ Diabetes ☐ Arthritis ☐ Muscle disease ☐ Scoliosis
☐ Hypertension ☐ Cancer ☐ Drug allergies ☐ Abnormal bleeding ☐ Other:____________

Living parents? Mother: Yes No Died at age _____of _________
Father: Yes No Died at age _____of _________

Current Work Status:

Years at Position: ______________________
☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Lifting How many hours per day ____
· If lifting at work, what is the average weight? ___ lbs. How often?______

Lifestyle Habits:

☐ Tobacco?______ (#packs/day) Years smoked?_____
☐ Caffeine beverages? _____ (#/day) ☐ Alcohol? _____(#drinks/day)
Are you currently exercising regularly? ☐ Yes; how many minutes per day?_____
☐ No; last regular exercise? ________________________________
Has your condition prevented you from doing exercise? ☐ Yes ☐ No

Past Medical History: **(please check all that apply)**

☐ Cancer ☐ Arthritis ☐ Alcoholism ☐ Kidney Disease ☐ Anorexia/Bulimia ☐ Liver Disease ☐ Diabetes ☐ Seizures ☐ Lung Disease ☐ Thyroid Disease ☐ Osteoporosis ☐ High Cholesterol ☐ Ulcer ☐ Glaucoma ☐ Heart Disease ☐ Tuberculosis ☐ Pacemaker ☐ Thyroid Problems ☐ AIDSHIV ☐ Hepatitis ☐ Diverticulitis ☐ High Blood Pressure
☐ Tumors/Growths ☐ Ulcers ☐ Stroke ☐ Anemia ☐ Blood Thinner ☐ Asthma ☐ Herniated Disc
☐ Hernia ☐ Joint Replacement ☐ Depression/Anxiety ☐ Allergies ☐ Prostate Problems
Other(s)? ____

Surgeries/Hospitalizations Injuries/Fractures/Dislocations

Procedure and year: _________________________ Procedure and year: _________________________________
Procedure and year: _________________________ Procedure and year: _________________________________
Procedure and year: _________________________ Procedure and year: _________________________________
Procedure and year: _________________________ Procedure and year: _________________________________

List of all supplements and medications you are currently taking: ___________________________________
____
____

Drug Allergies? ☐ Yes ☐ No **If yes, what**: ____

Review of Symptoms: (please check all that apply)

☐ Fever ☐ Fatigue ☐ Unexplained weight loss ☐ Night sweats ☐ Sore throat ☐ Abrupt change in vision ☐ Chest Pain ☐ Cough ☐ Abrupt change in hearing ☐ Nausea ☐ Vomiting ☐ Difficulty swallowing ☐ Bleeding ☐ Diarrhea ☐ Difficulty breathing ☐ Poor circulation ☐ Rash ☐ Pain/Swollen joints ☐ Dizziness ☐ Numbness ☐ Muscle weakness ☐ Hot Flashes ☐ Bruise easily ☐ Allergies to pollen ☐ Burning during urination ☐ Immune system dysfunction ☐ Loss of bowel/bladder control ☐ Difficulty sleeping ☐ Depression ☐ Anxiety ☐ <u>INFECTIONS</u>: ☐Urinary Tract ☐Respiratory ☐ Skin

☐**Other**____

SCHIERLING CHIROPRACTIC, LLC
Pain/Disability Index Questionnaire
Duties under Duress/ Loss of Enjoyment of Life

For each of the categories listed, circle the number that best represents your overall functional status (not just at its worst).

A score of **0** means you have **no** pain or disability. A score of **10** means that area of your life is **completely disrupted by pain or dysfunction**. Please use the comment line for any additional information that you feel the doctor needs to be informed of.

1. **Occupation:** Activities that are directly related to your job. Includes non-paying jobs such as homemaker or volunteer.

0 1 2 3 4 5 6 7 8 9 10

Able to function With no problems — Totally **unable** to function

Comments:

2. **Family/Home:** Refers to household chores, family activities, intimacy, or errands.

0 1 2 3 4 5 6 7 8 9 10

Able to function With no problems — Totally **unable** to function

Comments:

5. **Sleeping:** [ ] I can never seem to get comfortable.
[ ] If I do sleep, it is not for very long.

0 1 2 3 4 5 6 7 8 9 10

Able to function With no problems — Totally **unable** to function

Comments:

6. **Self Care:** Showering, eating, breathing, getting dressed, etc.

0 1 2 3 4 5 6 7 8 9 10

Able to function With no problems — Totally **unable** to function

Comments:

7. **Recreation/Exercise:** Hobbies, gardening, knitting, sewing, sports, exercise, etc.

0 1 2 3 4 5 6 7 8 9 10

Able to function With no problems — Totally **unable** to function

Comments:

8. **Social Activities:** Parties, theater, concerts, eating out, church.

0 1 2 3 4 5 6 7 8 9 10

Able to function With no problems — Totally **unable** to function

Comments:

9. **Traveling/Driving:**

0 1 2 3 4 5 6 7 8 9 10

Able to function With no problems — Totally **unable** to function

Comments:

(continued on next page)

10. **Walking:** [ ] I walk more slowly because of pain.
[ ] I walk shorter distances due to pain.

____0____1____ _2_____3______4_____5_____6______7______8______9______10___________

Able to function With no problems — Totally **unable** to function

Comments:____

11. **Lifting/Bending/Twisting:** Includes jobs, hobbies, family responsibilities, sports, etc.

____0____1____ _2_____3______4_____5_____6______7______8______9______10___________

Able to function With no problems — Totally **unable** to function

Comments:____

12. **Sitting:** [ ] I must change positions frequently.
[ ] I can only sit for short amounts of time without getting up and moving.
[ ] Sitting is the only relief from back pain.

____0____1____ _2_____3______4_____5_____6______7______8______9______10___________

Able to function With no problems — Totally **unable** to function

Comments:____

In general, would you say your health is:

[ ] Excellent [ ] Very good [ ] Good [ ] Fair [ ] Poor

Compared to one year ago, how would you rate your health in general *now*?

[ ] Much better now than one year ago.
[ ] Somewhat better now than one year ago.
[ ] About the same.
[ ] Somewhat worse now than one year ago.
[ ] Much worse now than one year ago.

Loss of Enjoyment of Life:

List the areas that, as a direct result of your injuries you feel you have lost your enjoyment of life:____
____
____
____

Duties under Duress:

List the activities you do each day which are difficult for you to perform due to your injuries, but, must be done regardless of how you are feeling.

____
____
____
____

Total Score: __________ Signature:______________________________Date:____________

Schierling Chiropractic, LLC
1219 S. State Route 17
Mountain View, MO 65548

417-934-6337

Notice of Patient Privacy Policy

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Cheryl James

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students. For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name.

Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We do not have have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *disclosures of psychotherapy notes*
- *uses and disclosures of Protected Health Information for marketing purposes;*
- *disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object
In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office*. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location.</u>** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **<u>You may have the right to have your doctor amend your protected health information.</u>** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***<u>You have the right to be notified by our office of any breech of privacy of your Protected Health Information.</u>***

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:*
http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf
Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Cheryl James. You may contact our Privacy Officer, or any staff member, including Dr. Schierling at the following phone number 417-934-6337, or our website, at www.doctorschierling.com for further information about the complaint process.

I have read your consent policy and agree to its terms. I am also acknowledging that I have been offered a copy of this notice. Due to space constraints in your file, we will only be keeping page 5, the signed and dated page of our policy as a matter of record.

______________________________ ____________________

signature date witness date

This notice was published and becomes effective on June 1, 2015