Dr. Scott E. Hollis, DC, DABCI, FICPA
Chiropractic Family Practice
Chiropractic Internist
Chiropractic Physician
Chiropractic Pediatrics

Hollis-tic Health & Hyperbaric Healing Center

1209 NW North Ridge Dr., Suite A ◊ Blue Springs, MO 64015 ◊ 816-228-5433

NEW PATIENT TREATMENT CONTRACT AND PAYMENT AGREEMENT

PATIENT ADMITTANCE FORM

NAME OF <u>WHO REFERRED</u> YOU -or- <u>HOW DID YOU HEAR</u> OF OUR WELLNESS CLINIC? → → → → → _____

Date _____ Patient Legal Name _____ Nickname _____
Address _____ City _____ State ____ Zip _____
Phone (Cell) _____ Phone (W) _____ (Parent Name If Minor) _____
Date of Birth _____ Age ____ Sex ____ Email Address _____
Social Security # _____ (required) Driver's License # _____ State _____
Spouse's Name _____ Phone _____ Email Address _____
Your Employer _____ Employer Address _____
Your Occupation _____ Child Name(s) +Ages _____
Emergency Contact Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Our fee structure is based as a Cash-Fee-For-Service System in which ALL FEES are at or below customary fees in the surrounding area. Our low-cost primary health service fees are designed to fit well with any financial budget and our clinic policy to help every person get the care they need without financial barriers. This clinic practices as an out-of-network or non-participating clinic regarding insurance claims, however, any completed payment for services can be submitted by you, the patient, for reimbursement directly back to yourself from your insurance company. If you desire to submit claims yourself to an insurance company, we will issue you a "Superbill" upon your request. If **<u>Finances</u>** are a roadblock to receiving treatment, **<u>Please Ask</u>** to speak with the Staff, as we offer options like HSA/FSA Accounts, AFLAC Claims, Financial Freedom Payment Plans, CareCredit, and Discount Family Plans.

TREATMENT AUTHORIZATION

By signing below, I hereby authorize and indemnify this office, the staff and doctor to examine and treat my bodily complaints as the doctor deems appropriate. I have been given informed consent and hereby authorize and consent to any/all procedures to be performed. I understand and agree that all services rendered me are charged directly to me and that I am responsible for payment in full for services performed, along with all outside laboratory and/or diagnostic services performed on my behalf, <u>immediately at the time services are rendered before departing the premises, unless other financial arrangements are made in writing in advance to services being provided</u>. If collection of unpaid and/or past due service fees become necessary, I accept responsibility to pay for all charges, fees, interest at 9% APR, and any associated collections / attorney fees in addition to treatment service fees. I, the undersigned, do hereby <u>agree to pay a service fee of $35 per 15-minute appointment block for any canceled or missed appointment occurring without having given at least "twenty-four (24) business hours" notice in advance via Phone Call Only !!!!</u>

(Business Hours are Monday, Wednesday & Thursday 9am-1pm / 3pm-7pm, and Tuesday 9am-3pm ONLY. The clinic is closed Friday, Saturday & Sunday)

Patient Signature (X) _____ Date _____

CONSENT TO TREAT A MINOR

I (we), _____, being the parent(s), guardian(s) or custodian(s) of patient above, do hereby authorize, give consent for, request, and direct this office, its doctors and staff to perform any examination, diagnostic test, X-ray, and/or treatment that, in their judgment, is deemed necessary while said minor is under care of this office's doctors and staff until legal age. All charges for services given to said minor will be charged directly to me (us) and I (we) <u>will be personally responsible for payment at time services are rendered, and all above applies</u>.
Parent, Guardian, or Custodian Signature(s) (X) _____ Date _____

MAJOR COMPLAINTS – Page 2 of 3

Patient Name: _____ Date: _____ DOB: _____ Age: _____ Sex: _____

(COMPLETE ALL AREAS THAT APPLY, IF NOT, SKIP)

What is (are) your major complaint(s) ranked in priority? (Detailed) _____

_____

_____

_____

_____

Is it related to a Fall or Accident? (Describe) _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____ When? _____ How many times? _____

What do you believe is wrong with you? _____

What are you seeking from this clinic as goals? _____

□ Relief Care – relief of current symptoms, but the underlying structural cause may still remain and symptoms may recur in the future.

□ Corrective / Rehabilitative Care – relief of current symptoms AND treatment of the underlying structural causes of this problem.

□ Preventative / Maintenance Care – relief now and prevention of future occurrences and other issues where possible.

The condition is getting: □ Worse □ Same □ Better □ Consistent □ Recurring □ Progressively Worse □ Insidious / Unexplainable

How does this condition interfere with your work or daily routine? _____

At what time of the day is the condition worse? □ Upon Awakening □ Mid-Morning □ Afternoon □ Evening □ Night (sleeping)

What activities make this condition worse? _____

_____

What activities make this condition better? _____

_____

Names of other doctors seen for this condition _____

Name of hospital for treatment or imaging studies (and what tests performed) _____

Previous diagnosis for this condition _____

Type of previous treatment and/or surgery for this condition _____

Duration of previous treatment for this condition _____

Results & Type of previous treatment: □ Good □ Fair □ Poor □ Other _____ Method/Technique: _____

Medications presently taking? _____ (more space below)

OTHER COMPLAINTS

What other conditions or problems are you presently being treated for, or are concerned about? _____

_____

Are you also seeking our help for these conditions? _____

PREVIOUS CHIROPRACTIC CARE

Name of Chiropractor _____ Address _____

Condition treated _____ Were X-rays taken? _____

Type of treatment received _____ Results of treatment _____

Date of last visit _____ **Reason for leaving, if any?** _____

PREVIOUS HEALTH PROBLEMS

Circle any of the following you have had OR are presently having:

□ Fractured bones	□ Spinal taps	□ Fainting
□ Dislocation	□ Scoliosis	□ Birth defects
□ Joint replacement	□ Diabetes	□ Osteoporosis
□ Metal screws/implants	□ High blood pressure	□ Cancer
□ Cervical whiplash	□ Stroke	□ Tumor
□ Electronic implant	□ Aneurysm	□ Cyst
□ Pacemaker	□ Convulsions	□ Ear infections
□ Herniated Disc	□ Seizures	□ Birth Complications
□ IBS	□ Memory lapse	□ Asthma
□ Pinched nerve	□ Dizziness	□ Bed wetting
□ Spinal surgery	□ Concussion	□ Heart attack
□ Spinal injections	□ Knocked unconscious	□ Incontinence
□ Warfarin-Cumadin Med	□ Headaches	□ Bowel/Gut Trouble

Are you pregnant? Y N

How many weeks gestation?_____

□ **Any past / present illnesses diagnosed?**

_____

_____

_____

□ **Any past Surgeries / Hospitalizations?**

_____

_____

□ **Medications / Supplements now taking?**

_____

_____

_____

_____

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FINANCIAL RESPONSIBILITY

***** I clearly understand that all services rendered me are my responsibility and payment is expected at the time services are rendered, before leaving the premises, unless other financial arrangements are made in advance with clinic management. *****

Printed Patient's Legal Name: _____

Patient's Legal Signature (X): _____ **Date:** _____

If under 18 years of age, Parent(s) or Guardian(s) Name: _____

Parent(s) or Guardian(s) Signature: _____

Informed Consent

Chiropractic is a system of diagnosis and treatment based on the concept that the nervous system coordinates all of the body's functions, and that disease results from a lack of normal nerve function.

Chiropractic employs manipulation and adjustment of body structures, such as the spinal column, so that pressure on nerves coming from the spinal cord due to displacement (subluxation) of a vertebral body may be relieved. Practitioners believe that structural misalignment and nerve pressure can cause problems not only in the local area, but also at some distance from it, including internal organs!!!

Doctors of Chiropractic are primary care physicians in the state of Missouri. However, their treatment is not designed to take the place of any treatments your medical doctor may have recommended.

Doctors of Chiropractic are not licensed to prescribe prescription medication nor advise patients regarding their prescription medication. At this clinic, we feel that nutrition is fundamental to the healing process and to maintain wellness. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment, but is not to be construed as the diagnosis or treatment for any disease of condition, and not to be considered as advice in lieu of recommended medical advice or treatment. I have read and understand the above:

Patient, Parent, or Guardian Legal Signature (X): _____ **Date:** _____

All pages of this agreement have been witnessed and verified by the following clinic staff member(s):

Witness 1 Name: _____ **Witness 2 Name:** _____

Witness 1 Signature: _____ **Date:** _____

Witness 2 Signature: _____ **Date:** _____