HEIGHTS ATLAS ORTHOGONAL CHIROPRACTIC CLINIC
3444 SE 6TH AVENUE, TOPEKA, KS 66607
785-354-8909 FAX 785-354-8202

WELCOME! Please allow our staff to photocopy your driver's license & insurance card (if applicable)

- ☐ DL Copied DATE _____
- ☐ Insurance Card Copied

Patient's Name _____ Preferred Name _____
Address_____ City _____ State _____Zip_____
Date of Birth _____ AGE _____ M F SSN_____
Home Phone #1 _____ Work Phone #2 _____Cell Phone #3 _____
May we leave a message /voicemail on Phone #1, Phone #2 or Phone #3 to remind you of your appointment? Yes No
If I am unavailable, you may leave a message with: _____ Relationship_____
Work Status FT PT UE/R/DA Student Marital Status S M D W # of Children _____
Ethnicity: Non-Hispanic ___ White ___ Mexican-American ___ African-American ___ Mexican ____ Other _____
Primary Language _____ Handedness: Right ____ Left _____ Ambidextrous ____
Employer: _____ Occupation: _____
Employer Address: _____City, State: _____ Zip _____
Females: Last Menstrual Period: _____ Pregnant: Y N If Yes Due Date _____Nursing: Y N
Spouse, Parent or Guardian Name: _____ Age _____ DOB _____
Spouse, Parent or Guardian Employer _____ Occupation _____
Spouse, Parent or Guardian Phone Number _____ 2nd Number: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person _____ Relationship to Patient: _____
Home Phone #1 _____Work Phone #2_____Cell Phone #3 _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

Is visit related to an Accident? N Y If so? Home ____ Car ____ Work ____
If your visit is related to an accident please explain, use the back if needed, Claim # _____
Primary Insurance _____ Ins Phone # _____
Policy Holder's Name _____DOB_____ SSN _____
Insurance ID Number _____Group Number _____ Effective Date _____
Relationship to Policy Holder: Self ___ Spouse ___ Child ____ Other ____ Need Pre Authorization Y N Referring Physician _____ Clinic Name _____

Do you have any other insurance coverage? Y N
Secondary Insurance_____ Ins Phone # _____
Policy Holder's Name _____DOB_____ SSN _____
Insurance ID Number _____Group Number _____ Effective Date _____
Relationship to Policy Holder: Self ___ Spouse ___ Child ____ Other ____ Need Pre Authorization Y N
Referring Physician _____ Clinic Name _____

NAME: _____ DATE: _____

Pain Area 1 _____ Left Side or Right Side? Location: _____
Describe your pain on a pain Scale of 1 to 10 with 1 being low pain and 10 being severe pain _____
When did it start? _____ Did it come on Gradually or Immediately?
Minimal _____ Slight _____ Mild _____ Mild-Moderate _____ Moderate _____ Moderate-Severe _____ Severe _____
Frequency: Intermittent _____ Occasional _____ Frequent _____ Constant _____
Describe the Feeling of your pain: Sharp___ Dull___ Achy___ Shooting ____ Spasm _____ Numb___ Tingling___ Burning___
Stabbing___ Stiffness___ Other_____
Does the pain Radiate? Y N At Times Where to: Head___ Neck ___ Shoulder ___ Arm ___ Hand ___ Hip ___
Leg ___ Foot ___ Other _____
What makes it better? _____ What makes it worse? _____
Is the pain worse in morning, afternoon or evening? Is the pain: BETTER WORSE SAME
Can you go to sleep? Y N At times Does the pain wake you up? Y N At times

Pain Area 2 _____ Left Side or Right Side? Location: _____
Describe your pain on a pain Scale of 1 to 10 with 1 being low pain and 10 being severe pain _____
When did it start? _____ Did it come on Gradually or Immediately?
Minimal _____ Slight _____ Mild _____ Mild-Moderate _____ Moderate _____ Moderate-Severe _____ Severe _____
Frequency: Intermittent _____ Occasional _____ Frequent _____ Constant _____
Describe the Feeling of your pain:
Sharp___ Dull___ Achy___ Shooting ____ Spasm _____ Numb___ Tingling___ Burning___ Stabbing___ Stiffness___
Other_____
Does the pain Radiate? Y N At Times Where to: Head___ Neck ___ Shoulder ___ Arm ___ Hand ___ Hip ___
Leg ___ Foot ___ Other _____
What makes it better? _____ What makes it worse? _____
Is the pain worse in morning, afternoon or evening? Is the pain: BETTER WORSE SAME
Can you go to sleep? Y N At times Does the pain wake you up? Y N At times

Pain Area 3 _____ Left Side or Right Side? Location: _____
Describe your pain on a pain Scale of 1 to 10 with 1 being low pain and 10 being severe pain _____
When did it start? _____ Did it come on Gradually or Immediately?
Minimal _____ Slight _____ Mild _____ Mild-Moderate _____ Moderate _____ Moderate-Severe _____ Severe _____
Frequency: Intermittent _____ Occasional _____ Frequent _____ Constant _____
Describe the Feeling of your pain:
Sharp___ Dull___ Achy___ Shooting ____ Spasm _____ Numb___ Tingling___ Burning___ Stabbing___ Stiffness___
Other_____
Does the pain Radiate? Y N At Times Where to: Head___ Neck ___ Shoulder ___ Arm ___ Hand ___ Hip ___
Leg ___ Foot ___ Other _____
What makes it better? _____ What makes it worse? _____
Is the pain worse in morning, afternoon or evening? Is the pain: BETTER WORSE SAME
Can you go to sleep? Y N At times Does the pain wake you up? Y N At times

Is any of the Three pain areas interfering with your: Work____ Sleep ____ Daily Routine ____ Recreation____?
If so, which areas of pain are affected? _____
Number of hours of normal sleep _____ Do you feel rested upon waking? Yes No
Have you had sleep problems before? Yes No
Have you lost time from work due to any of the above listed pain Yes No If yes, How Long? _____

NAME: _____ DATE: _____

Do you have pain/problems when performing Activities of Daily Living (ADL) such as: (X for Yes)

___ Seeing ___ Tasting ___ Smelling ___ Eating ___ Hearing ___ Bathing ___Grooming

___ Dressing ___ Holding ___ Pinching ___ Standing ___ Leaning ___ Walking ___ Stooping

___ Squatting ___ Climbing ___ Kneeling ___ Bending ___ Twisting ___ Carrying ___ Lifting

___ Pushing ___ Pulling ___ Reaching ___ Sitting ___ Driving ___ Riding in Car ___ Air Travel

___ Sports ___ Exercising ___ Loss of Sexual Drive ___ Reclining ___ Restful Sleep

___ Insomnia ___ Using the toilet ___ Loss of Concentration ___ Nervousness ___ Irritability

___ Personality Change ___ Tactile Feeling ___ Other _____

Do you use a cane, walker, wheelchair, or another device to help you walk or ambulate? _____

Please mark all other applicable health related symptoms or conditions that apply:

___ Headache
___ Facial Pain
___ Blurred Vision
___ Dizziness
___ Earache
___ Eye Pain
___ Forgetfulness
___ Confusion
___ Sinusitis
___ Teeth Grinding
___ Dry Mouth
___ Excessive Thirst
___ Unpleasant Taste
___Neck Pain
___Sore Throat
___Lump in Throat
___Swallowing Pain
___Unsteady Voice
___Shoulder Pain
___Persistent Coughing
___Chest Pressure
___Slow heart Rate
___Rapid Heart Rate

___ High Blood Pressure
___ Low Blood Pressure
___ Abdominal Pains
___ Nausea/Vomiting
___ Poor Appetite
___ Fullness of Bladder
___ Urination Difficulty
___ Frequent Urination
___ Constipation
___ Diarrhea
___ Hemorrhoids
___ Decreased Sex Drive
___ Menstrual Irregularities
___Elbow/Hand Pain
___ Tingling in Hands
___ Clammy Hands
___ Low Back Pain
___ Hip Pain
___ Knee Pain
___ Poor Circulation
___ Swollen Joints
___ Joint Pain
___ Swollen Ankles

___ Ankles/Foot Pain
___ Tingling in Feet
___ Walking Difficulties
___ Sore Muscles
___ Weak Muscles
___ Paralysis
___ Shakiness
___ Sweating
___ Insomnia
___ Fainting
___ Convulsions
___ Irritability
___ Impatience
___ Fatigue
___ Feel loss of Control
___ Mid-back pain
___ Other _____
_____

ADDITIONAL

___ Seizures
___ Transplant
___ Surgically Implanted Device
___ Pacemaker/Defibulator

NAME: _____ DATE: _____

Have you ever been in an Automobile Accident or other physical trauma: __ Past Year __ 1-5 Years __ 5+ years __ Never
Describe Accident: _____
_____
_____
_____

Work Activity: __ Heavy Labor __ Moderate Labor __ Light Labor __ Mostly Sitting __ Mostly Standing
__ Walking/Moving __ Driving

Exercise Type: ___ Heavy ___ Moderate ___Light ___ none

Surgical History from birth to current: _____
_____
_____
_____

Smoking: ___ Never ___ Current ____ Every Day Started _____ (Year)

___ Current ___ Some days Started _____ (Year) ____

___ Former Started _____ (Year) Quit _____(Year)

Allergies: __ None __ Medication __ Environment/Seasonal __ Animals __ Latex

Allergies/Sensitivities to Medication

Name of Medicine	Allergic to or Sensitive to?	Reaction to Medicine (Rash, Nausea, Vomiting, etc.)

Medications: Currently taking: __ None

Name of Medicine	Dosage Amount	Reason for Medication

Date Med list was updated by patient_____ Initial _____
Date Med list was updated by patient_____ Initial _____
Date Med list was updated by patient_____ Initial _____
Date Med list was updated by patient_____ Initial _____
Date Med list was updated by patient_____ Initial _____

NAME: _____ DATE: _____

Family History: (G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

___ Allergies	___ Eczema	___ Miscarriage(s)	___ Tumors
___ Alcoholism	___ Emphysema	___ Mumps	___ Ulcers
___ Anemia	___ Epilepsy	___ Pleurisy	___ Female Organ Dysfunction
___ Cancer	___ Goiter	___ Pneumonia	___ Over Weight
___ Deep Vein Thrombosis (DVT)	___ Gout	___ Polio	___ Headaches/Migraines
___ Detached Retina	___ Heart Disease	___ Rheumatic Fever	___ Addiction
___ Diabetes	___ HIV/AIDS	___ Stroke	___ Other: _____

The information given here, is true to the best of my knowledge.

PATIENT PRINTED NAME

PATIENT SIGNATURE DATE

NAME: _____ DATE: _____

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Heights Atlas Orthogonal Chiropractic Clinic, PA or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

NAME: _____ DATE: _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I, [print name], _____, hereby request and consent to the performance of services rendered at HEIGHTS ATLAS ORTHOGONAL CHIROPRACTIC CLINIC, PA, which may include but are not limited to, applicable x-rays, examinations, evaluations, diagnostic procedures, diagnoses, consulting services, rendered in conjunction with chiropractic adjustments, treatments as indicated and/or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of HEIGHTS ATLAS ORTHOGONAL CHIROPRACTIC CLINIC, PA, on me (or the patient named below for whom I am legally responsible): _____ by the licensed Doctor of Chiropractic (D.C.) and/or anyone working in this office authorized by the licensed Doctor of Chiropractic (D.C.).

I further understand that such chiropractic services may be performed by the Doctor of Chiropractic (D.C.) named here **Dr. Connie Lang and/or Dr. Stacy Struble**, **D.C.** and/or other licensed Doctors of Chiropractic (D.C.) who may treat me now, or in the future, at this office. I have had an opportunity to discuss with **Dr. Connie Lang and/or Dr. Stacy Struble**, **D.C.** and/or with other office or clinic personnel the nature and the purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: soreness, fractures, disc injuries, strokes (CVA), death, dislocations, sprains, and increased symptoms and pain, or no improvement of symptoms or pain. I do not expect the Doctor to be able to anticipate and explain all the risks and complications. Further I wish to rely on the Doctor of Chiropractic to exercise judgement during the course of any and all procedure(s) which the Doctor feels are in my best interests at the time, based upon the facts then known.

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment at HEIGHTS ATLAS ORTHOGONAL CHIROPRACTIC CLINIC, PA. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Agreement for Payment of Services:

By signing the authorization above I affirm that I understand and agree that:

- health and accident insurance policies are an arrangement between patients and their insurance carriers;
- any amount that is authorized to be paid directly to Heights Atlas Orthogonal Chiropractic Clinic, PA will be credited to my account upon receipt. I permit this office to endorse insurance payments to be applied to my account;
- all services rendered to me are charged directly to me and that I am personally responsible for the payment of my account; and
- it is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made in advance.

SIGNED on this _____ day of _____, 20___.

PRINT NAME: _____

SIGNATURE: _____

NAME: _____ DATE: _____

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PATIENT FINANCIAL RESPONSIBILITY

This office will provide insurance billing services for you. If you so desire as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier. Your signature o this document indicated that you agree to pay for any outstanding charges incurred in this office.**

Patients who do not have health insurance:

Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Time of Service rates when their accounts are paid in full on each visit. A written copy of our fee schedule is available upon request.

Patients with deductible have two options:

1. You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is net, your plan will most likely switch to a co-pay or co-insurance status.
2. You can pay our Wellness fees. Wellness fees are significantly less than our regular fees. Wellness fees are not reimbursable by insurance and you are wholly responsible or these fees.

We will strive to work out feasible payment options for anyone who is in the need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. Office policy dictates that delinquent accounts may be referred to TEK COLLECT for collection which may include possible blemishes on your credit record. If this happens, an administrative fee of $18.00 (minimum) may be added to your account to cover our costs.

I authorize payment of insurance benefits directly to ***Heights Atlas Orthogonal Chiropractic Clinic, P.A.*** *I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment.* By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____ _____

Signature of responsible party (Parent or Legal Guardian) Date