NORTHLAND MEDICAL CENTER, LLC

Patient Application Survey / Medical Intake

Last Name:_____________________ First Name:__________________________ MI:__________ Age:________ Please Circle: Male / Female

Address:____ City, State,Zip:____

Home Phone:__________________________ Cell Phone:__________________________ Email:__________________________

Employer:__________________________ Work Phone:__________________________ Date of Birth:_____/_____/_________

Marital Status (please circle): Single Married Divorced Social Security # ___________________________________

Family Physician:____Phone:______________________

Purpose Of This Visit

Please list condition(s) in order of concern:

1.) ________________________________ 2.)________________________________ 3.)________________________________

Is this condition(s) related to an auto accident or work injury? ≤ Yes ≤ No

Describe:____

When did this condition begin/when did you first notice it:____

Describe:____

What activities aggravate your symptoms?____

Is there anything that has relieved your symptoms? ≤ Yes ≤ No

Describe:____

Have you experienced this condition before? ≤ Yes ≤ No

Who have you seen for this?_______________________________ What did they do?____

How did you respond?____

How committed are you to getting rid of your problem ≤ Very committed ≤ Not very committed

Please list any prescription medications that you are taking or have taken in the past 6 months:

1. ______________________________ **2.** ______________________________ **3.** ______________________________

4. ______________________________ **5.** ______________________________ **6.** ______________________________

7. ______________________________ **8.** ______________________________ **9.** ______________________________

Please list any over the counter medications that you are taking or have taken in the past 6 months:

1. ______________________________ **2.** ______________________________ **3.** ______________________________

4. ______________________________ **5.** ______________________________ **6.** ______________________________

7. ______________________________ **8.** ______________________________ **9.** ______________________________

Please list any supplements that you are taking or have taken in the past 6 months:

1. ______________________________ **2.** ______________________________ **3.** ______________________________

4. ______________________________ **5.** ______________________________ **6.** ______________________________

7. ______________________________ **8.** ______________________________ **9.** ______________________________

NORTHLAND MEDICAL CENTER, LLC

Medical History: Please check all that apply

θ AIDS
θ Arthritis
θ Allergies (Hay fever)
θ Anemia
θ Asthma
θ Alcoholism
θ Blood Pressure
θ Bronchitis
θ Cancer
θ Chronic Fatigue Syndrome
θ Carpal Tunnel Syndrome
θ Chest Pain
θ Cholesterol-Elevated
θ Circulatory Problems
θ Colitis
θ Dental Problems
θ Depression
θ Diabetes

θ Diverticular Disease
θ Emphysema
θ Epilepsy
θ Eyes, Ears, Nose Throat
θ Environmental Sensitivities
θ Fibromyalgia
θ Gastroesophageal Reflux
θ Glaucoma
θ Gout Heart Disease
θ Heart Attack
θ Infection, Chronic
θ Inflammatory Bowel Disease
θ Irritable Bowel Syndrome
θ Kidney or Bladder Disease
θ Kidney Stones
θ Liver or Gallbladder Disease
θ Migraine Headaches

θ Neurological Problems
θ Sinus Problems
θ Stroke
θ Obesity
θ Osteoporosis
θ Sexually Transmitted Disease
θ Seasonal Affective Disorder
θ Shortness of Breath
θ Skin Problem
θ Stroke
θ Ulcer
θ Urinary Tract Infections
θ Varicose Veins
θ Thyroid

Other____________________

Operations:

θ Appendectomy
θ Prostate
θ Cholecystectomy
θ Tonsillectomy
θ Hysterectomy
θ ____________________

Allergies (please list):

θ ______________________________ θ ______________________________ θ ______________________________

Social History: Please circle all that apply.

Married: Yes No If yes, how long _____________ Children: Yes No If yes, how many____________________

Occupation____

Tobacco : Yes No Please Circle: Cigarettes Cigars Chewing Tobacco If yes, how much/day_________How many years_________

Alcohol: Yes No If yes, drinks/day or week_________ Coffee: Yes No If yes, cups/day_________

PMI/FH:
Have any of your family members had any of the problems listed in the chart? Please indicate by checking the appropriate box.

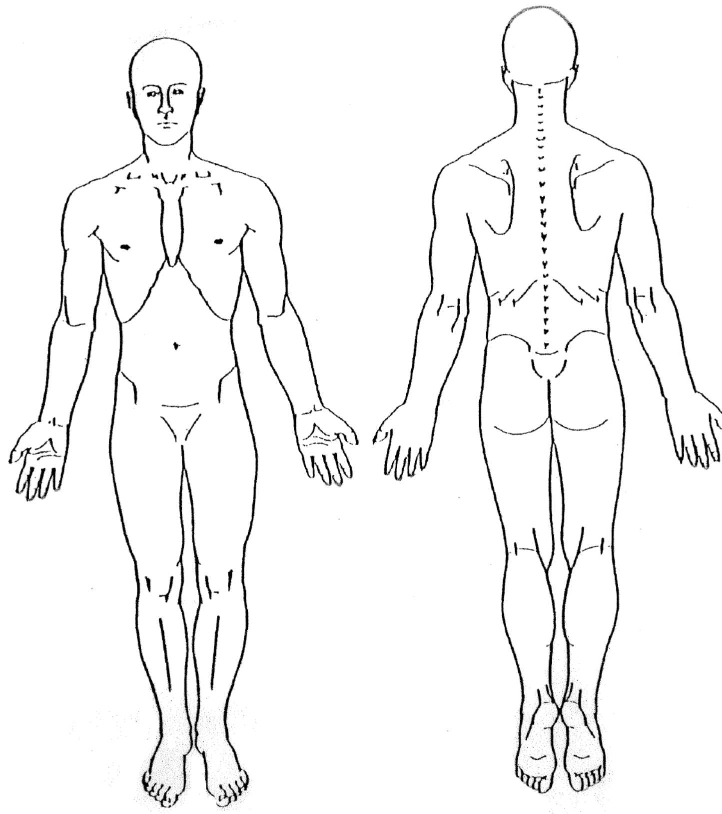
	Father	Mother	Grandparents	Siblings	Children
Alcoholism					
Anemia					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Heart Disease					
High Blood Pressure					
Osteoporosis					
Mental Illness					
Thyroid Disorders					

Please check the boxes below that reflect <u>any</u> symptoms that you may be experiencing or experienced in the past 6 months:

NORTHLAND MEDICAL CENTER, LLC

	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head							
Neck							
Upper Back							
Mid Back							
Lower Back							
Shoulder							
Arm							
Forearm							
Wrist							
Hand							
Ribs							
Buttock							
Hip Thigh							
Leg							
Knee							
Ankle							
Foot							

Please circle/mark your area(s) of the signs and symptoms listed



NORTHLAND MEDICAL CENTER, LLC

INSURANCE COMPLIANCE INFORMATION

We would like to take a moment to welcome you to our office and assure you that your treatment is our top priority. We find that many patients are very confused when using their insurance and are concerned about their financial obligations. This form is utilized to explain your responsibilities when our office files your insurance.

At Northland Medical Center, our staff provides you with all insurance filing at the time of service. We will verify all insurance benefits to assure your chiropractic/medical coverage's in full. However, we need to make you aware that these benefits are not a guarantee of payment and you will ultimately be responsible for all services that are not paid by your insurance company. It is very important that you understand that our office, as a service to our patients, will submit and make all attempts to collect all outstanding payments. We will not enter into any disputes with your insurance company. If your account remains in an outstanding status, our staff may request your help in expediting payment from your insurance company.

Each patient is required to meet their deductible in full before their insurance company will pay their portion. At this time, our staff will notify you of your out of pocket expense at your time of service. Most insurance company policies require a payment of 30%-50% of the patients visit. Our staff is required to collect this amount at the time of service. If your insurance policy requires a co-pay, this amount will be requested at the time of service. It has become a standard that doctors' request all payment in full at the time of service. Our office continues to service our patients the old fashion way and will do the work for you. This allows you to focus on your health.

Personal Injury Patient With Health Insurance:
If you were involved in an automobile accident and have a health care policy, our office will submit all charges at the time of service. You will not be responsible to pay for any deductible or co-pay at the time of service. Any outstanding balance will be reimbursed by your attorney when your case is settled.

What To Do When My Insurance Company Sends Me A Check:
Many insurance companies will send the member (patient) a check to your home instead of our office by accident. If this situation occurs, please be advised that you are to bring the check and accompanying explanation of benefits to the office so that it can be posted to your account.

What Do I Do If My Insurance Company Sends Me Forms That I Do Not Know How To Answer?
Many times an insurance company will send a patient a questionnaire for them to fill out. These forms purposely are used as stall tactics and are quite confusing for you to understand. When you receive these letters, please either call our office or bring them to our office manager for proper clarification.

Financial Consent/Patient Agreement:
I understand and agree to the services that my doctor has offered to me. I agree to be fully responsible for any services that are not paid by my insurance company and understand that my doctor will send all outstanding accounts to a collection agency after 60 days if not reconciled by the responsible party.

I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problems.

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier to pay directly to Northland Medical Center, LLC such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Northland Medical Center, LLC. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Northland Medical Center, LLC. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Northland Medical Center, LLC. must take any action to collect an outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

__________________ _______________
Patient Initials Date

____
Insurance Company Name and Address

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for Northland Medical Center regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Northland Medical Center, 8335 N. Congress Ave, Kansas City, MO 64152, (816) 741-0018.

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for Northland Medical Center

FINANCIAL POLICY AND FEE DISCLOSURE

It is our office policy to provide all patients with the best possible care in the most cost-effective way.

Initial Exam	$249.00
X-Ray 2 views	$50.00
Adjustment only	$49.00
Manual Therapy	$55.00
Neuromuscular Re-Education	$55.00
E-Stim	$26.00
Posture Print	$60.00
Trigger Point Injections	$160.00
Therapeutic Exercises	$53.00
Heat	$12.00
Orthotics	$395.00
Ischial/Heel Lift	$10.00
Cervial Home Traction	$375.00
Lumbar Home Traction:	$450.00
Tens Unit:	$495.00
Electrodes:	$29.50
Custom Fit Lumbar Orthosis	$1307.00

Diagnostic Testing

Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system….$460.00
Non-invasive physiologic studies of extracranial arteries, complete bilateral study…………………………..$380.00
Non-invasive physiologic studies of upper and lower extremity arteries, multiple levels or
with provocative functional maneuvers, complete bilateral study…………………………………………….$530.00
Non-invasive physiologic studies of extremity veins, complete bilateral study……………………………….$427.00
Nerve Conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study………...$215.00
Nerve Conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study……………$207.50
Nerve Conduction, amplitude and latency/velocity study, each nerve; sensory or mixed……………………..$175.00
Short latency somatosensory potential study, stimulation of any/all peripheral nerves or
skin sites, recording from the central nervous system; in upper limbs………………………………………..$415.00
Short latency somatosensory potential study, stimulation of any/all peripheral nerves or
skin sites, recording from the central nervous system; in lower limbs………………………………………..$415.00
Visual evoked potential (VEP) testing central nervous system; in lower limbs………………………………$289.00
H reflex, amplitude and latency study; record gastrocnemius/soleus muscle…………………………………$215.00
Disposable Electrodes…………………………………………………………………………………………$29.50

Nutritional supplements, orthopedic supplies, and/or laboratory services would be an additional fee, which will be discussed prior to ordering.

Patient Initials:_________ Date:__________

NORTHLAND MEDICAL CENTER
CONSENT TO TREAT

I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, manipulation of the spine, nutritional support, trigger point injection and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

OPEN BAY TREATMENT AREA

I understand that Northland Medical Center, LLC utilizes an open bay treatment facility in which other patients will be receiving care at the same time as myself. I also understand that while every attempt will be made to maintain confidentiality, other patients will be able to observe my treatment and overhear conversations between myself and the staff of Northalnd Medical Center, LLC. I furthermore take full responsibility for informing the doctor if I wish any communication to be in a private setting. I am aware that if at any time I choose to discontinue treatment due to the open bay policy I am free to do so.

PRINT Patient's Name:____

Patient Initials:_________ Date:__________

SIGNATURE of Parent or Guardian:___________________________Date:__________

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____

θ There is a possibility that I may be pregnant at this time.
θ Yes. I am definitely pregnant
θ No. I am definitely not pregnant at this time
θ I request that x-ray films not be taken because ____
____

Date of last menstrual period: _____________________________________

_______________________________ __________
Patient's Signature Date

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

NORTHLAND MEDICAL CENTER, LLC

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

In consideration of your undertaking to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

(Including, but not limited to: medical billing/diagnosis)

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

ASSIGNMENT OF CAUSE OF ACTION

(Action to get your bills paid)

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company the name(s) of which is/are believed to be correctly set forth under pertinent data below, and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

To: ____

(Name of attorney and/or insurance company)

In consideration of the services rendered and to be rendered by Northland Medical Center, I authorize and direct the payment to the group named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by insurance company obligated to reimburse me for the charges for his services or otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Northland Medical Center
8335 North Congress Ave.
Kansas City, MO 64152

IF I RECEIVE THE CHECKS IN THE MAIL, I HEREBY PROMISE TO BRING ALL PAPERWORK AND THE CHECK OR CHECKS TO Northland Medical Center AND SIGN THEM OVER TO Northland Medical Center FOR PAYMENT OF SERVICES PROVIDED.

ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at the Northland Medical Center, and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either:

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge as assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or

B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the service of an attorney;

Then payment for services rendered by Northland Medical Center will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the _____ day of _______________, 20____

______________________ ______________________

Patient's Signature Patient's Name