BlueChip
SPINE & SPORTS SPECIALISTS

BLUECHIP SPINE & SPORTS SPECIALISTS, LLC
8336 E. 21ST ST N. WICHITA, KS 67206

PHONE: (316) 733-8338
FAX: (316) 733-8343

NEW PATIENT INFORMATION

Please Print all Answers

Name _____ Age _____ Sex _____ Date _____

Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Best time to Call _____ Which # _____ E-mail _____

Social Security # _____ Birthdate _____ Family Doctor _____

O Married O Single O Sep O Divorced O Widowed Spouse's Name _____

Employer _____ Spouse's Employer _____

Employer Address _____ Spouse's Birthdate _____

Employer Phone _____ Spouse's Social Security _____

Parent's Employer If Patient Is Minor / Child _____

Parents Social Security # If Patient Is Child _____

Emergency: Who Do We Call? _____ Relationship _____

Name of Patient or Friend who referred you _____ Phone _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birthdate _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____

Agent Name _____ Adjuster's Name _____

Accident Claim Number _____ Phone Number _____

Name of LIABLE Insurance Company _____ Adjuster's Name _____

Claim Number _____ Phone Number _____

Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____

Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering chiropractic, physical therapy and rehabilitation. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -4- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

CURRENT CONDITION

Are your present problems due to an injury? ❑Yes ❑No

Enter the date of the injury:___________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ___________________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other

Briefly describe the accident, injury or illness:

____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity associated with the symptom

___________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

___________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies:____

❑Medications:____

Were you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ______________________ Transported by? ❑Ambulance ❑Police ❑Other

Date Admitted: _______________ Date Released: _______________ Length of Stay: _______________

Have you seen another doctor for this condition? ❑No , If Yes whom?______________________________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

___________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________ To: ____________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?)

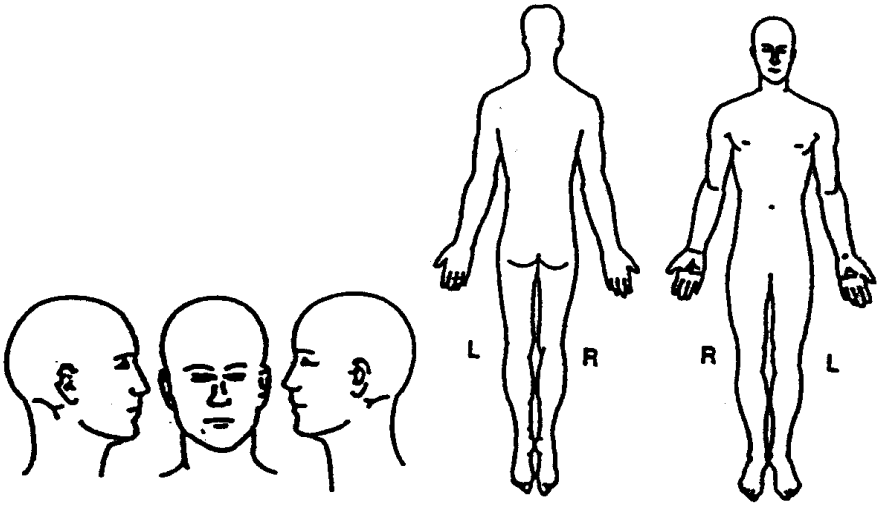
____

PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

(Please illustrate your pain):

Pain	: : : : : : : : : :
Numbness	+ + + + + +
Burning	/ / / / / / / / / /
Ache	X X X X X X



What if anything gives you relief? _____

PREVIOUS HISTORY

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No

_____

List any past conditions you may have had:

_____

HABITS

❑Smoking/Packs/day: _____

❑Drinking Alcohol: (Cups/day): __

❑Coffee Cups/Day: _____

❑Soft Drink Cans/Day: _____

❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑_____
Father	❑	❑	❑	❑_____
Brother(s)	❑	❑	❑	❑_____
Sister(s)	❑	❑	❑	❑_____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc?

❑Yes ❑No If yes, which ones?: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies? ❑Yes ❑No If yes, which ones?: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, enter type and approximate date of surgery.)

_____

Have you ever had X-rays taken? ❑Yes ❑No When? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current, or past symptom listed.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR/NOSE/THROAT	RESPIRATORY
❑ Allergy(What) _____	❑ Belching or Gas	❑ Asthma	❑ Chest Pain
❑ Bronchitis	❑ Colon Trouble	❑ Deafness	❑ Chronic Cough
❑ Headache	❑ Constipation	❑ Earache	❑ Spitting Blood
❑ Convulsions	❑ Diarrhea	❑ Ear Discharge	❑ Spitting Phlegm
❑ Dizziness	❑ Gall Bladder	❑ Ear Noises	
❑ Fainting	❑ Hemorrhoids (piles)	❑ Thyroid Problems	

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR/NOSE/THROAT	GENITO-URINARY
❑ Loss of Sleep	❑ Nausea	❑ Nasal Obstruction	❑ Blood in Urine
❑ Loss of Weight	❑ Stomach Pain	❑ Nose Bleeds	❑ Frequent Urination
❑ Nervousness	❑ Vomiting	❑ Pain in Eyes	❑ Urination Control
❑ Night Sweats	❑ Vomiting Blood	❑ Poor Vision	❑ Kidney Infection
❑ Numbness in _____	❑ Heart Burn	❑ Blurred Vision	❑ Kidney Stones
❑ Wheezing	❑ Bloody Stools	❑ Sinusitis	❑ Painful Urination

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis
❑Pneumonia	❑Measles	❑Goiter	❑Epilepsy
❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago
❑Tuberculosis	❑Diabetes	❑Alcoholism	❑Whooping Cough
❑Eczema	❑Cancer	❑HIV Positive	❑Venereal Disease

HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, BlueChip Spine & Sports Specialists, LLC will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility is not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. BlueChip Spine & Sports Specialists, LLC will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
8. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

Ψ

Signature (if minor, parent must sign)

Date