BATEMAN – GATROST CHIROPRACTIC, P.C.

19501 East US Hwy 40, Ste B Independence, MO 64055 Phone: 816 / 795-5000 Fax: 816 / 795-5001

L. Wayne Bateman, D.C. Carlos A. Bateman, D.C. Albert L. Gatrost, D.C. Robert A. Riley, D.C. Shelby J. Ripperger, D.C.

Date: _____ **Account #** _____

***First Name**_____ **Nick Name**_____

***Last Name** _____ **Middle Name** _____ **Suffix** _____

Address _____

City_____ **State**_____ ***Zip Code** _____

Home Phone _____ **Work Phone** _____

Mobile Phone _____ **I agree to text message appt reminders?** ❑ Yes ❑ No

Email _____ **I would also like an email appt reminder?** ❑ Yes ❑ No

By providing my email address, I authorize my doctor to contact me via the email address provided.

Primary Contact Method *(check one):* ❑ Home Phone ❑ Mobile Phone ❑ Work Phone

***Date of Birth** / / **Age** _____ **SSN** _____-_____-_____

***Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

Spouse/Parent/Legal Guardian Name_____ **Phone**: _____

Emergency Contact(s): _____**Phone**_____

Employment Status:*(check one)* ❑Employed ❑FT Student ❑PT Student ❑Other ❑Retired ❑Self Employed

*Occupation:_____

Employer Name:_____Employer Phone:_____

Employer Address:_____

City:_____State:_____Zip:_____

Primary Care Physician

*Provider Name_____Provider Phone/Fax:_____

Provider Address:_____

Briefly list your main health problems: _____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

If yes, where were they taken? _____

Patient Name_____ **Account #**_____ **Date** _____

Race *(Choose up to 2 options)*

❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian
❑ Native Hawaiian or other Pacific Island ❑Other_____ ❑ I choose not to specify

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify.

Preferred Language *(Choose up to 2 options)*

❑ English ❑ Spanish ❑ Chinese ❑ French ❑ German ❑ Italian
❑ Korean ❑ Russian ❑ Vietnamese ❑ Polish ❑ Arabic ❑ Portuguese
❑ Japanese ❑ Greek ❑ American Sign Language ❑ Other _____ ❑ I choose not to specify.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

***Has any doctor diagnosed you with Hypertension presently?** ❑ Yes ❑ No - If yes, describe: _____

***Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

***Has any doctor diagnosed you with Blood Clotting Disorder?** ❑ Yes ❑ No If yes, describe: _____

***Current Medications Prescribed by a doctor:** **If there are NO CURRENT MEDICATIONS, check here: ❑**

Medication: _____ Dosage: _____ ❑Generic ❑Brand Name ❑Unknown
Start Date: _____Current condition patient is taking medication for? _____

Medication: _____ Dosage: _____ ❑Generic ❑Brand Name ❑Unknown
Start Date: _____Current condition patient is taking medication for? _____

Medication: _____ Dosage: _____ ❑Generic ❑Brand Name ❑Unknown
Start Date: _____Current condition patient is taking medication for? _____

Medication: _____ Dosage: _____ ❑Generic ❑Brand Name ❑Unknown
Start Date: _____Current condition patient is taking medication for? _____

***Does your primary medical doctor have you on an Aspirin regimen? ❑ Yes ❑ No If yes, dosage:** _____

***How often do you depend on pain relievers - Acetaminophen, Ibuprofen, Marijuana, or other?(circle all that apply)**
❑ Daily ❑ ____/Week ❑ ____/month ❑ Rarely ❑ Other: _____

***List any known Allergies you have had to any medications. - If NO ALLERGIES are known, check here: ❑**

1) _____ 3) _____
2) _____ 4) _____

Have you seen a Chiropractor before? □ Yes □ No If yes, list name of doctor and date(s): _____

What condition were you treated for? _____

Did the treatment received help your condition? □ Yes □ No - How long were you treated? _____

How did you learn about our office? _____

Signature: _____ **Date:** _____

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Patient Name_____ **Account #**_____ **Date** _____

Reason for Visit

Purpose of this visit: ☐ Motor Vehicle Collision ☐ Slip/Fall ☐ Other: _____ In what State did this occur? _____

Date/Time of incident: _____ Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Wearing a seatbelt? ☐ Yes ☐ No Were you knocked unconscious? ☐ Yes ☐ No If yes, how long: _____

Where was the impact? ☐ Behind ☐ Front ☐ Driver's Side ☐ Passenger's Side Did airbag deploy? ☐ Yes ☐ No

Did you go to the Hospital? ☐ Yes ☐ No If yes, which hospital: _____

Transported to hospital via: ☐Ambulance ☐Drove Self ☐Driven by someone else. Were you admitted? ☐ Yes ☐ No

Have you gone to Urgent care or your PCP? ☐ Yes ☐ No If yes, Date and time: _____

Has a follow up been recommended by the treating doctor? ☐ Yes ☐ No If yes, Date and time: _____

In your own words, please describe the incident: _____

_____

_____

Did you have any physical complaints prior to the incident? ☐ Yes ☐ No If yes, please describe: _____

_____

Please describe your complaints and symptoms since the incident: _____

_____

Please list any activities of daily living or demands of employment that you could perform prior to the incident that you are unable to perform since the incident: _____

_____

Problem Areas:

*Describe your problem(s): _____

_____

*On a Scale of 0-10, rate the intensity: Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest

*How did your problem begin: _____

_____

*Onset date of problem: _____

How often do you experience symptoms:

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day

☐ Occasionally (26-50% of the day) ☐ None

Nature of your symptoms (mark all that apply): ☐ Burning ☐ Dull Ache ☐ Numb ☐ Radiating ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling

Does it affect other areas of your body: ☐ Yes ☐ No - What areas does the pain radiate, shoot, travel: _____

What makes the problem worse? (time of day, movements, activities): _____

What have you done to relieve the Symptoms? ☐ Acupuncture ☐ Chiropractic ☐ Heat ☐ Ice ☐ Massage Therapy ☐ Nothing Works ☐ Medication ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching/Exercise ☐ Therapy ☐ Other: _____ ☐ Other: _____

*What are your expectations of treatment for your current condition?

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own

☐ Reduce Symptoms ☐ Resume Normal Activity

Patient Name_____ **Account #**_____ **Date** _____

ACTIVITIES OF DAILY LIVING SUMMARY

Complete the following questionnaire as it relates to any activities (work or other) you would **normally be doing / enjoying**, but are **currently unable to perform normally** as a result of your injury (s), include all activities which you:

- Can no longer do or perform or enjoy
- Cannot do or perform/enjoy as you did **before** your injury

Job description _____

Specific work / school / home related challenges_____

_____

Please **CIRCLE** all activities that apply and rate the difficulty of the activity on a scale of 1-10(0 being the easiest, 10 most difficult):

Activity	Level of Difficulty	Reason for difficulty
Bending	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Carrying	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Driving	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Housework	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Lifting	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Lying	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Personal Care	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Pulling	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Pushing	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Reaching	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Reading	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Recreation	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Running	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Shopping	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Sit to Stand	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Sitting	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Sleeping	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Standing	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Walking	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Writing	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness
Other: _____	0 1 2 3 4 5 6 7 8 9 10	□ Increased Pain □ Restricted movement □ Weakness

Patient Name_____ **Account #**_____ **Date** _____

Oswestry Back Pain – Modified - For the Thoracic and Lumbar spine, we use the following assessment as a functional outcome tool to measure the level pain and disabilities specific to this area. If you have a Mid-Low back related issue please answer each section by clicking ONE choice that most applies to you.

Question 1 - Pain Intensity
- □ The pain is mild and comes and goes.
- □ The pain is mild and does not vary much.
- □ The pain is moderate and comes and goes.
- □ The pain is moderate and does not vary much.
- □ The pain is severe and comes and goes.
- □ The pain is severe and does not vary much.

Question 2 - Personal Care(Washing, Dressing, etc.)
- □ I do not have to change the way I wash and dress myself to avoid pain.
- □ I do not normally change the way I wash or dress myself even though it causes some pain.
- □ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- □ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- □ Because of my pain I am partially unable to wash and dress without help.
- □ Because of my pain I am completely unable to wash or dress without help.

Question 3 - Lifting
- □ I can lift heavy weights without increased pain.
- □ I can lift heavy weights, but it gives extra pain.
- □ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.)
- □ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Question 4 - Walking
- □ I have no pain when walking.
- □ I have pain when walking, but I can still walk my required normal distances.
- □ Pain prevents me from walking long distances.
- □ Pain prevents me from walking intermediate distances.
- □ Pain prevents me from walking even short distances.
- □ Pain prevents me from walking at all.

Question 5 - Sitting
- □ Sitting does not cause me any pain.
- □ I can only sit as long as I like providing that I have my choice of seating surfaces.
- □ Pain prevents me from sitting for more than 1 hour.
- □ Pain prevents me from sitting for more than ½ hour.
- □ Pain prevents me from sitting for more than 10 minutes.
- □ Pain prevents me from sitting at all.

Question 6 - Standing
- □ I can stand as long as I want without increased pain.
- □ I can stand as long as I want but my pain increases with time.
- □ Pain prevents me from standing more than 1 hour.
- □ Pain prevents me from standing more than ½ hour.
- □ Pain prevents me from standing more than 10 minutes.
- □ I avoid standing because it increases my pain right away.

Question 7 - Sleeping
- □ I get no pain when I am in bed.
- □ I get pain in bed, but it does not prevent me from sleeping well.
- □ Because of my pain, my sleep is only ¾ of my normal amount.
- □ Because of my pain, my sleep is only ½ of my normal amount
- □ Because of my pain, my sleep is only ¼ of my normal amount.
- □ Pain prevents me from sleeping at all.

Question 8 - Social Life
- □ My social life is normal and does not increase my pain.
- □ My social life is normal, but increases my level of pain.
- □ Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
- □ Pain prevents me from going out very often.
- □ Pain has restricted my social life to my home.
- □ I have hardly any social life because of my pain.

Question 9 - Traveling
- □ I get no increased pain when traveling.
- □ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- □ I get increased pain while traveling, but it does not cause me to seek alternative forms of travel.
- □ I get increased pain while traveling which causes me to seek alternative forms of travel.
- □ My pain restricts all forms of travel except that which is done while I am lying down.
- □ My pain restricts all forms of travel.

Question 10 - Employment/Homemaking
- □ My normal job/homemaking activities do not cause pain.
- □ My normal job/homemaking activities increase my pain, but I can still perform all that is required of me.
- □ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- □ Pain prevents me from doing anything but light duties.
- □ Pain prevents me from doing even light duties.
- □ Pain prevents me from performing any job or homemaking chores.

Patient Name_____ **Account #**_____ **Date** _____

Neck Disability Index (Vernon Mior) - **For the cervical spine, we use the following assessment a functional outcome tool to measure the level of cervical related pain and disabilities. If you have a Cervical related issue please answer each Section by marking ONE choice that most applies to you.**

Question 1 - Pain Intensity
- □ I have no pain at the moment
- □ The pain is very mild at the moment
- □ The pain is moderate at the moment
- □ The pain is fairly severe at the moment
- □ The pain is very severe at the moment
- □ The pain is the worst imaginable at the moment

Question 2 - Personal Care (washing, dressing, etc.)
- □ I can look after myself without causing extra pain.
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself, I am slow and careful
- □ I need some help but manage most of my personal care
- □ I need help every day in most aspects of self care
- □ I do not get dressed, wash with difficulty and stay in bed

Question 3 - Lifting
- □ I can lift heavy weights without extra pain
- □ I can lift heavy weights, but it gives extra pain.
- □ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- □ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift very light weights.
- □ I cannot lift or carry anything at all.

Question 4 - Reading
- □ I can read as much as I want with no pain in my neck.
- □ I can read as much as I want with slight pain in my neck.
- □ I can read as much as I want with moderate pain in my neck
- □ I cannot read as much as I want because of moderate pain in my neck
- □ I can hardly read at all because of severe pain in my neck
- □ I cannot read at all

Question 5 - Headaches
- □ I have no headaches at all.
- □ I have slight headaches which come infrequently.
- □ I have moderate headaches which come infrequently.
- □ I have moderate headaches which come frequently.
- □ I have severe headaches which come frequently.
- □ I have headaches almost all the time.

Question 6 - Concentration
- □ I can concentrate fully when I want to with no difficulty.
- □ I can concentrate fully when I want to with slight difficulty.
- □ I have a fair degree of difficulty in concentrating when I want to.
- □ I have a lot of difficulty in concentrating when I want to.
- □ I have great deal of difficulty in concentrating when I want to.
- □ I cannot concentrate at all.

Question 7 - Work
- □ I can do as much work as I want to.
- □ I can only do my usual work, but no more.
- □ I can do most of my usual work, but no more.
- □ I cannot do my usual work.
- □ I can hardly do any work at all.
- □ I cannot do any work at all.

Question 8 - Driving
- □ I can drive without any neck pain.
- □ I can drive as long as I want with slight pain in my neck
- □ I can drive as long as I want with moderate pain in my neck.
- □ I cannot drive as long as I want because of moderate pain in my neck
- □ I can hardly drive at all because of severe pain in my neck
- □ I cannot drive my car at all

Question 9 - Sleeping
- □ I have no trouble sleeping.
- □ My sleep is slightly disturbed (less than 1 hr. sleepless)
- □ My sleep is mildly disturbed (1-2 hrs. sleepless)
- □ My sleep is moderately disturbed (2-3 hrs. sleepless)
- □ My sleep is greatly disturbed (3-5 hrs. sleepless)
- □ My sleep is completely disturbed (5-7 hrs. sleepless)

Question 10 - Recreation
- □ I am able to engage in all my recreation activities with no neck pain at all.
- □ I am able to engage in all my recreation activities with some pain in my neck.
- □ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- □ I have neck pain with most recreational activities.
- □ I can hardly do any recreation activities because of pain in my neck
- □ I cannot do any recreation activities at all

Patient Name:_____ **Account #** _____

TODAY I FEEL:

□ About the same □ Somewhat improved □ Much Improved □ No more complaints

Please mark on the bodies everywhere your pain is located today. Then on the Pain Scale circle the level of your pain for each area marked. 0 is no pain and 10 is the worst pain you can imagine.

PAIN SCALE

Headache

0 1 2 3 4 5 6 7 8 9 10

Neck

0 1 2 3 4 5 6 7 8 9 10

Shoulder-Arm

0 1 2 3 4 5 6 7 8 9 10

Mid Back

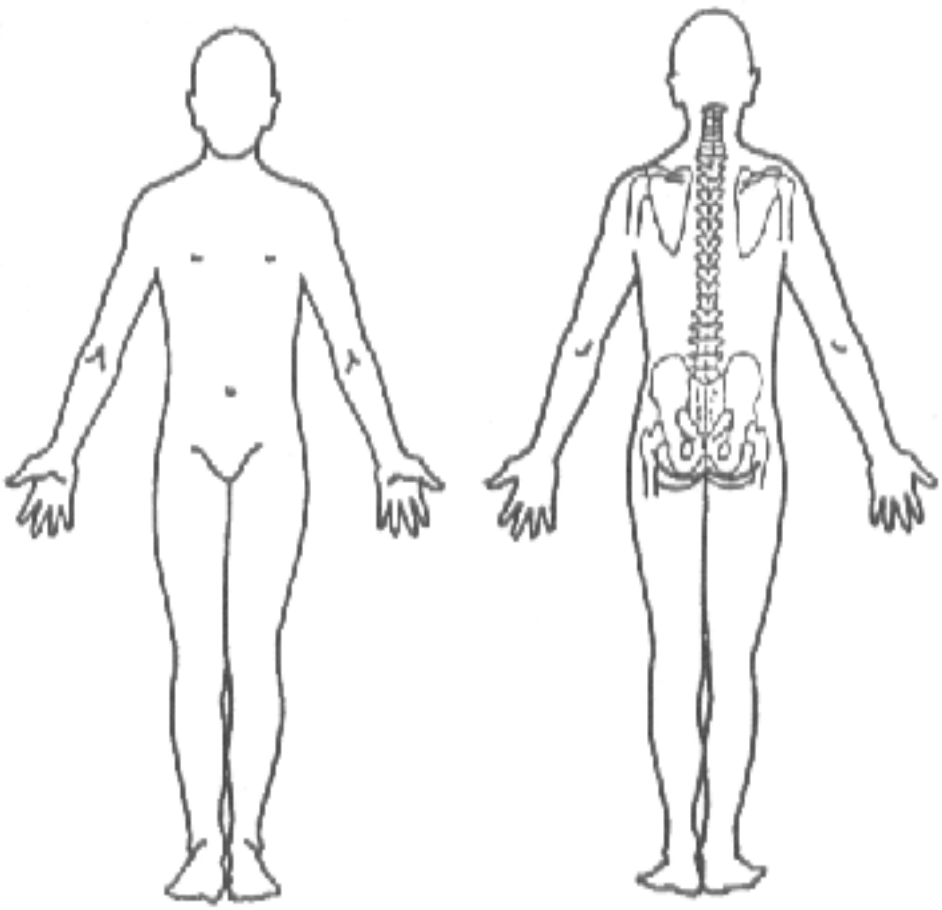
0 1 2 3 4 5 6 7 8 9 10

Low Back

0 1 2 3 4 5 6 7 8 9 10

Hip-Leg

0 1 2 3 4 5 6 7 8 9 10



Additional Comments:

_____

_____

_____

_____ _____

Signature Date

Patient Name:_____ **Account #** _____

Medical History

Illnesses: Condition: _____ Start date: _____ End date: _____
Condition: _____ Start date: _____ End date: _____

Surgeries/ Hospitalizations Procedure/Reason: _____ Date: _____
Procedure/Reason: _____ Date: _____
Procedure/Reason: _____ Date: _____

Injuries: Injury: _____ Date: _____
Injury: _____ Date: _____

Family History

Please list any family member (ie: father, mother, sister, brother, child) that has a history of a serious health condition or disease.

STROKE		**OTHER:**	
CANCER (TYPE)		**OTHER:**	
HEART DISEASE (TYPE)		**OTHER:**	
HEMOPHILLIA		**OTHER:**	
HYPERTENSION		**OTHER:**	
OSTEOPOROSIS		**OTHER:**	

Social History

How many ounces of liquid do you consume on a daily basis? ____Water ____Coffee ____Soda ____Alcohol ____Other
How much regular exercise do you perform: _____
How much physical stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot
How much emotional stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot
How many hours do you sleep per night: _____ What is your preferred sleeping position: _____

Acknowledgements

☐ **Chiropractic, Physical Therapy, and Massage Therapy Treatment**: I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

☐ **Permission to contact**: I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

☐ **Payment Verification**: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

☐ **X-ray Verification: (females only)**: I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period:

☐ **General Verification**: To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature:_____ **Date:** _____

Bateman-Gatrost Chiropractic-Motor Vehicle Collision/Personal Injury Filing Policy

Patient's Name:_____ **Account #:**_____ **Today's Date:**_____/_____/_____

Due to the fact that the doctors at Bateman-Gatrost Chiropractic are participating providers with most health insurance plans we are required by contract to bill the most responsible party. Therefore a Doctor's Lien will be filed with the attorney, med pay and/or third party liability insurance company as applicable. Our office will send all billing and medical records to these parties on your behalf for reimbursement. Bateman-Gatrost Chiropractic, P.C. will be reimbursed **100%** for services rendered.

It is important to understand that all monies received by the patient for services rendered at Bateman-Gatrost Chiropractic, P.C. are to be brought to the office to be applied to the account and that although your attorney, med pay or third party liability may pay less than the actual bill for services, you agree to pay the balance within 30 days. Even though you are ultimately responsible for yourself and your dependents, Bateman-Gatrost Chiropractic, P.C. will wait for settlement of your claim up to **ninety (90) days** after your care is completed. If your claim has not been settled by the end of the 90 days, you hereby agree to pay the account balance in full. **If you suspend or discontinue care at any time, you hereby agree to pay the account balance immediately.**

Initials: _____

I do hereby authorize the above Chiropractic facility to furnish my attorney/insurance company(s), with a full report of this case history, examination, diagnosis, treatment and prognosis of myself and/or my dependent in regard to the accident/illness, which occurred or began on:

Date of Accident: _____/_____/_____ **State:** _____ **Initials:** _____

____**OPTION 1:** I would like to pay **Cash** at time of service.

____**OPTION 2**: I would like to file **Med Pay** insurance coverage provided by **my** auto insurance.
Insurance Company:_____
Insurance Address: _____
Insurance Adjuster's Name:_____
Adjuster's Phone Number:_____
Claim Number:_____

____**OPTION 3:** I would like to file **Third Party Liability** insurance coverage provided by the **other party's** auto insurance.
Insurance Company:_____
Insurance Address: _____
Insurance Adjuster's Name:_____
Adjuster's Phone Number:_____
Claim Number:_____

____**OPTION 4**: I would like to file with my **Attorney.**
Legal Firm: _____
Attorney's Name:_____
Address:_____
Telephone Number:_____

I have read, understand and agree to the terms of the Bateman-Gatrost Chiropractic Motor Vehicle Collision/Personal Injury Filing Policy. Should I default on the terms of this agreement, I understand my account will be turned over to collections without notice and I will be responsible for all fees incurred to resolve this issue.

_____	_____	____/____/____
Print Patient's Name	Witness	Date
_____	_____	____/____/____
Patient/Legal Guardian Signature	Relationship	Date

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L. Wayne Bateman, D.C. Carlos A. Bateman, D.C. Albert L. Gatrost, D.C. Robert A. Riley, D.C. Shelby J. Ripperger, D.C.

COMMERCIAL ASSIGNMENT OF BENEFITS & RELEASE:

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE AND, IN CONSIDERATION OF SERVICES RENDERED, ASSIGN DIRECTLY TO BATEMAN – GATROST CHIROPRACTIC, P.C. ALL PAYMENTS FROM MEDICAL HEALTH BENEFITS, AND / OR ANY PAYMENTS FROM MY ATTORNEY, THIRD PARTY PAYOR, MEDICAL / PIP COVERAGE, IF ANY, OTHERWISE PAYABLE TO ME. I AUTHORIZE THE RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

PATIENT INITIALS_____

MEDICARE AUTHORIZATION:

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO BATEMAN – GATROST CHIROPRACTIC, P.C. FOR ANY SERVICES FURNISHED TO ME BY SAID PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO BATEMAN – GATROST CHIROPRACTIC, P.C. AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT MEDICARE & MEDICARE ADVANTAGE INSURERS REQUIRE AN EXAM AND NECESSARY X-RAYS; HOWEVER, MEDICARE AND MEDICARE ADVANTAGE INSURERS **DO NOT COVER** ANY CHARGES FOR **EXAM, X-RAY, OR THERAPY**.
MEDICARE & MEDICARE ADVANTAGE INSURERS COVER **SPINAL ADJUSTMENTS ONLY.**

PATIENT INITIALS_____

AUTHORIZATION TO DISCLOSE INFORMATION:

I, THE UNDERSIGNED, HERE BY AUTHORIZE BATEMAN-GATROST CHIROPRACTIC TO RELEASE ANY AND ALL INFORMATION REGARDING MY CONDITION, TREATMENT, AND FINANCIAL STATUS AS IT RELATES TO MY CASE TO THE FOLLOWING:

1.) _____ PHONE #: _____
2.) _____ PHONE #: _____
3.) _____ PHONE #: _____

PATIENT FINANCIAL AGREEMENT:

I, THE UNDERSIGNED, AGREE TO PAY FOR THE BALANCE OF MY ACCOUNT. ALTHOUGH AN INSURANCE CLAIM (IF APPLICABLE) WILL BE FILED WITH MY INSURANCE COMPANY ON MY BEHALF, NEGOTIATING PAYMENT THROUGH MY INSURANCE COMPANY ULTIMATELY IS MY OBLIGATION. IF I HAVE NO INSURANCE, I AGREE THAT PAYMENT WILL BE MADE AT THE TIME SERVICES ARE RENDERED UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE **PRIOR** TO THE SERVICES. A STATEMENT WILL BE MAILED MONTHLY SHOWING ANY BALANCE DUE FROM ME AND IS CONSIDERED PAST DUE WITHIN 30 DAYS FROM RECEIPT. IF I DO NOT RECEIVE A STATEMENT WITHIN 45 DAYS OF MY VISIT, IT IS MY RESPONSIBILITY TO CONTACT BATEMAN – GATROST CHIROPRACTIC, P.C. TO VERIFY MY CURRENT ADDRESS AND ANY BALANCE DUE. IF I AM UNABLE TO MAKE PAYMENT IN FULL, I SHOULD CALL THE BILLING DEPARTMENT IMMEDIATELY TO MAKE PAYMENT ARRANGEMENTS.

I UNDERSTAND THAT ITEMS BILLED TO INSURANCE BECOME PAST DUE IF NO REPLY IS RECEIVED WITHIN 45 DAYS. I UNDERSTAND THAT IF NO PAYMENT HAS BEEN RECEIVED OR FINANCIAL ARRANGEMENTS MADE ON MY BALANCE AFTER 45 DAYS, MY ACCOUNT MAY BE REFERRED FOR COLLECTION. IF REFERRED FOR COLLECTION, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE BALANCE AS WELL AS ANY FEES INVOLVED IN THE COLLECTION PROCESS.

TREATMENT TIME IS VALUABLE, **IF YOU CANNOT KEEP YOUR APPOINTMENT PLEASE CALL**; OTHERS MAY NEED CARE. IT IS THE GOAL OF BATEMAN-GATROST CHIROPRACTIC, P.C. TO ALWAYS PROVIDE THE BEST STANDARD OF CARE POSSIBLE. STRICT ADHERENCE TO THE PRESCRIBED TREATMENT PLAN WILL MAXIMIZE THE OUTCOME OF CARE**.**

I UNDERSTAND IT IS MY RESPONSIBLITY TO PROVIDE CURRENT IDENTIFICATION VERIFICATION AND INSURANCE CARD AT CHECK IN. TIME OF SERVICE CHARGE IS PROVIDED AND PAYMENT IN FULL IS REQUIRED THE SAME DAY OF SERVICE.

_____ _____
Patient Name – please print Date

_____ _____
Patient Signature/Parent or Legal Guardian if minor Relationship to Patient

BATEMAN – GATROST CHIROPRACTIC, P.C.

19501 East US Hwy 40, Ste B Independence, MO 64055 Phone: 816 / 795-5000 Fax: 816 / 795-5001

L. Wayne Bateman, D.C. **Carlos A. Bateman, D.C.** **Albert L. Gatrost, D.C.** **Robert A. Riley, D.C.** **Shelby J. Ripperger, D.C.**

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Bateman-Gatrost Chiropractic P.C.

I understand that the Notice describes the uses and disclosures of my protected health information by Bateman-Gatrost Chiropractic P.C. and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*