F.I.T Muscle & Joint Clinic - Olathe
2113 East Kansas City Road
Olathe, KS 66061
913-791-0144
https://www.fitmjc.com

Patient Intake Form

Please take a moment to completely fill out this form to help us better serve your healthcare needs. Upon completion of all form categories please email to Olathe@fitmjc.com or print and bring to the first appointment.

Patient Information

Personal Information

* First Name:

Middle Name:

* Last Name:

Gender: ○ female ◉ male

Date of Birth: / /

Height: feet inches

Weight:

Parent(s)/Guardian(s) Name:

Number of Siblings:

Contact Information

* Email:

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

Home Phone:

Cell Phone:

Work Phone:

Address Line 1:

Address Line 2:

City:

State/Province/Region:

Zip/Postal Code:

Emergency Contact:

Relationship:

Phone:

Current Condition

What is the reason for your visit?

○ wellness ○ complaint ○ injury ○ physician referral ◉ other

Please briefly describe concern/origin of complaint/injury/other. If referred by physician, please list below.

Have you received prior care for this concern?

◉ yes ○ no

If yes, explain:

****If current complaint pertains to a recent injury, skip the following developmental questions****

Please fill in age that your child developed the following skills:

Rolling over:

Sitting up:

Crawling:

Pulling to stand:

Cruising:

Independent Standing:

Independent Walking:

Do you have any concerns regarding your child's development?

○ Yes ◉ No

If yes, explain:

What (if any) special equipment does your child use?

wheelchair

eye glasses

hearing aid/device

brace

walker

crutches

communication device

other

If other, explain:

Health History

Please list any of your child's medical precautions/allergies/medications:

Please list any significant hospitalizations, illness, surgeries, etc:

Please list any significant prenatal or birth history:

Is your child receiving any other therapy services, or have they in the past? If yes, explain.

Family History- Please list any diagnosed health conditions or untimely deaths (condition and relationship):

Family members include: Parents,siblings,maternal and paternal grandparents/aunts/uncles. Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

Family/Primary Physician

Date of last physical exam: / /

Name of Physician or Pediatrician:

Physician Phone:

Physician City:

Physician State:

Physician Zip:

Please list any health conditions your child has been treated for in the last year: (condition, cause, current/resolved)

Insurance and Payment for Care

How do you plan to pay for your child's care?

◉ personal insurance ○ third party insurance ○ self pay

Name of party responsible for payment:

Responsible party phone:

Primary Insurance

Insurance Name:

Phone:

Address:

City:

State:

Zip:

ID/Policy #:

Group #:

Insured's Name:

Insured's Date of Birth: / /

Secondary Insurance

Insurance Name:

Phone:

Address:

City:

State:

Zip:

ID/Policy #:

Group #:

Insured's Name:

Insured's Date of Birth: / /

Authorization

INFORMED CONSENT Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulations/adjustments is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of my complication from treatment and I freely assume these risks. TREATMENT RESULTSI also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility, function, and reduced muscle spasm. However, I acknowledge there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing. ALTERNATIVE TREATMENTS AVAILABLEreasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises, and possible surgery.Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be confirmed indefinitely. Some medications may involve serious risks. Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily, reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues. Surgery: Surgery may be necessary for joint instability or serious dis rupture. Surgical risks may include unsuccessful outcome, complications, pain, or reaction to anesthesia, and prolonged recovery.Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy. I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. Financial/Privacy Policy and DisclaimerInsurance Verification Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing. Deductible Payments It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report form the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request. Collection of Patient Balance Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service. If an "Explanation of Benefits" of EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. Payment is due within 30 days of receipt of the bill. In the event a bill is disputed, you must notify use within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us. All balances remaining unpaid after 30 days may be turned over to a collection agency.Returned Checks It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction. Appointments If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice.Financial Policy Questions We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator(s) Chad Barnes or Matthew Lane.HIPAA Privacy Policy Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you. By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies. Designation of Authorized Representative I do hereby designate F.I.T. Muscle & Joint Clinic to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 €FR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from F.I.T. Muscle & Joint Clinic. These rights include the right to act on my be-half with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies. IRREVOCABLE Power of Attorney I do hereby authorize F.I.T. Muscle & Joint Clinic act on my behalf to pursue claims and exercise all rights in order to collect insurance payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from F.I.T. Muscle & Joint Clinic. Appointments: If you are unable to keep an appointment, as a courtesy to our staff and other patients, please give 24 hours notice. Patients who cancel with less than 24 hours notice will be charged a $30.00 "Late Cancellation Fee." Patients who do not show up for an appointment and do not call to cancel that appointment ("No Call, No Show") will be charged a No Call, No Show/Cancellation fee of $55.00. The patient will be responsible for payment. In addition, cancellations and "No Call, No Show" for appointments made outside of normal clinic hours will be charged full "Time of Service" fee.By clicking "SUBMIT" you are hereby ELECTRONICALLY SIGNING this authorization form and acknowledge all information/statements contained within.

* **I agree with this statement of authorization**

Signature (guardian's signature if under 18 years of age)

By signing your name in the textbox below, you are authorizing it as your official signature and agreeing to the terms above.

* Signature:

Date: / /