CHIROPRACTIC CASE HISTORY

Please complete this entire questionnaire. This confidential history will be part of your permanent records. Please have your insurance card and driver's license ready so a copy can be made. *THANK YOU*.

Name_____Date of Birth_____
Address_____Marital Status S M D W
City_____State_____Zip_____**email**_____
SS#_____Home Phone_____Work Phone_____
Cell Phone_____
_____Initial here if Dr. Wertel's office has your permission to leave a detailed message on your voicemail.
Occupation_____Employer_____

Employer's Address_____City_____Zip_____

What is your major complaint?_____
_____

How long have you had this condition?_____

Have you had similar conditions in the past?_____

Is your condition due to an accident?_____Work_____Auto_____Other_____

Is this condition: _____improved_____unchanged_____getting worse

Is this condition interfering with your:_____work_____sleep_____daily routine_____other

Who else has treated THIS condition?_____

What do you think caused THIS condition? _____

List any surgical procedures with the years and any current health conditions:_____

_____

Family physician: _____

His/her address:_____

Will you be filing insurance?_____What type?_____

How did you hear about the office?_____

X_____
Patient's or Guardian's Signature Date:

Additional Patient Information Form

Are you currently taking any medications? Yes No
If yes, please list

Are you allergic to any medications? Yes No
If yes, please list

What is your smoking status? Please circle one

Current every day smoker Current some day smoker

Former smoker Never smoker

NO SHOW AND CANCELLATION POLICY

Effective July 19, 2021 if you "no show" for your appointment you will be required to pay a $25 cancellation fee prior to being seen again.
For every block of time that is not used because someone did not show up for their appointment or a short notice cancellation is time taken away from another patient needing our care.
Cancellations can be via speaking to staff, phone messages or email.
I understand times are difficult and that everyone's circumstances are different, however everyone's time is valuable.

Patient Signature:_____Date:_____

PAIN LOCATION AND RATING

Name:_____Date:_____

Date of Birth:_____ Age: _____ Occupation: _____

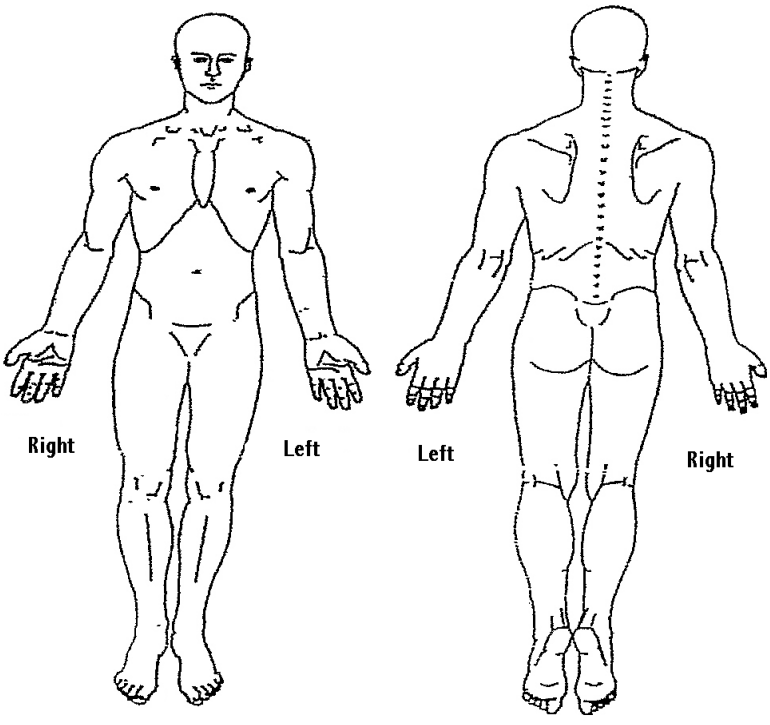
INSTRUCTIONS: Make a mark (--) along the line at the level, which you think best represents your CURRENT amount of pain related to your present injury or condition.

Pain As Bad As It Could Be

No Pain At All

INSTRUCTIONS: Indicate where your pain is located and what type of pain you feel at the PRESENT time. Use the symbols below to describe your pain. Do NOT indicate areas of pain, which are not related to your present injury or condition.

KEY: /// Stabbing XXX Burning
= = = Numbness *** Aching
000 Pins and Needles



ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE FOR CHIROPRACTIC CHARGES

I hereby assign and authorize payment made directly to South City Injury and Rehabilitation of the covered insurance benefits including major medical benefits, whether payable to me by Medicare, commercial insurance companies and/or managed care plans. I understand that my health insurance provider may not cover part or all of the medical services rendered.

I fully understand that I am financially responsible for and agree to pay all charges not paid by my health care coverage, including deductibles, co-insurance, and payments from insurance companies sent to me directly. In consideration of the chiropractic services furnished to me, I hereby agree to pay South City Injury and Rehabilitation any balance due within ninety days from presentation of my bill. If my account should become delinquent and collection efforts become necessary, I agree to pay any responsible collection or attorneys fees incurred.

I have disclosed the names of all my health insurance providers' including tie-in-coverage and I represent that such health care coverage is in full force and effect at this time.

If prior authorization or certification for chiropractic services is required under my health care coverage, I agree to obtain both and furnish such authorization for certification.

I authorize the release of medical information as may be required to process the claims for payment of the chiropractic services rendered and it is expressly understood that the right of such information to be privileged is hereby waived. I understand that I have an opportunity to discuss with the Doctor and staff to my satisfaction the nature of the services to be provided.

I acknowledge that no guarantees have been made to me as to the results.

This assignment shall apply to all chiropractic services now rendered and to be rendered in the future until it is revoked. I agree to promptly notify your office of any change of address or change of insurance. A copy of this assignment shall be considered as valid as the original.

I voluntarily consent to the participation of care, including treatment.

I certify that the information given by me in applying for payment under Title XVIII and of Title XI of the Social Security Act, is correct. I authorize release of any medical records concerning me to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance. If my account has a balance, my credit/debit card may be charged if a reasonable attempt to reach me has failed. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

X_____ **X**_____

Signature of Patient (Guardian) Date

HIPAA Notice of Privacy Practices

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Gerald J. Wertel, DC PC
DBA: South City Injury and Rehabilitation
5425 Chippewa St.
St. Louis, MO 63109
(314) 352-7000

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures **Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

I give you permission to release any information to the following Doctors, Clinics or People:

_____ _____

_____ _____

_____ _____

_____ _____