Welcome! Please Complete The Following:

Date | Name | Preferred Name

Street Address | City, State | Zip Code

Best Phone Number to Reach You | Best Email Address

Date of Birth | Age | Social Security Number

Employer Name and Address | Occupation | Years at Current Employer

Best Phone Number to receive appointment confirmation text: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Would you like to subscribe to our email list for all the latest deals at Curis? ☐ Yes ☐ No

Insurance/Billing Information

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

***To prevent billing errors**, we ask all patients share a copy of their current insurance card upon renewal*

Insurance Company | Subscriber's Name | Relationship To You

Subscriber's SSN | Subscriber's DOB | Address, City, State, Zip

Emergency Contact Name | Relationship to the Patient | Phone Number

Medical Doctor's Name | Medical Doctor's Address/General Location

May We Contact Your Medical Doctor Regarding Your Care (Y/N)? _____

Curis FUNCTIONAL HEALTH

What is your major complaint? Please List Any Other Complaints

How did this/these condition(s) develop?

Date of onset: _____ Have you had similar problems in the past? _____

What aggravates your condition? Does anything offer relief? (Please List)

Is your major complaint getting worse? ☐ Yes ☐ No

How would you describe the condition? ☐ Constant ☐ Comes and goes

How would you describe your discomfort? ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numbness or Tingling

What percent of the day does this condition bother you? ☐< 25% ☐ 25% - 50% ☐ 50% - 75% ☐75% - 100%

What would you rate the level of discomfort on a scale of 0 - 10? (0=no pain, 10=extreme pain)_____

Have you had previous chiropractic care? ☐ Yes ☐ No

Have you been treated by others for this condition? ☐ Yes ☐ No

If Yes, Please List Who Has Treated You? _____

Who Can We Thank for Referring You? _____

Health History

Please list all medications you are currently taking (names, amounts, and how often)

Please list all supplements, vitamins and herbs you are currently taking

Do you exercise regularly? ☐ Yes ☐ No

If Yes, What Kind of Exercise/How Often _____

If No, What Prevents You? _____

Curis
FUNCTIONAL HEALTH

Please check all the following health conditions that apply:

☐ Heart Attack / Stroke / Heart Defect	☐ Heart Surgery/Pacemaker	☐ Heart Murmur or Artificial Valves
☐ Congenital Heart Defect	☐ Mitral Valve Prolapse	☐ Whiplash
☐ Alcohol / Drug Abuse	☐ Venereal Disease	☐ Hepatitis
☐ HIV+ / AIDS	☐ Shingles	☐ Cancer
☐ Frequent Neck Pain	☐ Emphysema/Glaucoma	☐ Anemia
☐ High / Low Blood Pressure	☐ Psychological Problems	☐ Rheumatic Fever
☐ Severe or Frequent Headaches	☐ Kidney Problems	☐ Ulcers / Colitis
☐ Fainting / Seizures / Epilepsy	☐ Sinus Problems	☐ Asthma / Difficulty Breathing
☐ Diabetes	☐ Chemotherapy	☐ Osteoporosis
☐ Lower Back Pain	☐ Artificial Bones/Joints	☐ Arthritis

_____

Please list any other serious medical condition(s) you have ever had

_____

List any previous surgeries with dates

Please list any accidents with dates (Car, Serious Falls)

What Position Do You Sleep In? _____ Do You Wake Feeling Rested (Y/N)? _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day: _____ How long have you been smoking? _____

Do you feel there are goals to reach in regard to your health (Y/N)? _____ If Yes, Explain: _____

_____

_____

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

☐ I understand that ANY bounced or returned checks will be charged a $25 processing fee and Curis reserves the right to no longer accept this form of payment on future services.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.

➡Signature_____ ➡Date_____/_____/_____

For use and/or disclosure of Protected Health Information (PHI) to carry out treatment, payment and healthcare operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Curis Functional Health's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Curis to provide treatment to me, and also necessary for Curis to obtain payment for that treatment and to carry out the health care operations. Curis explained to me that the Privacy Notice would be available to me in the future at my request. Curis has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Curis reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. Curis's "Notice of Privacy Practices" is also provided in the front lobby. I may also request a copy from this office at any time via US Mail, or email.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

*****I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

Office Policy, Acknowledgements, and Consents

- I understand that the cost of services is payable at the time the service is rendered.
- I understand that the Insurance Benefits quoted to me are not a guarantee of payment from my insurance company. If my insurance company processes claims differently than the benefits are described to me, I am responsible for any additional money that may be owed since per the insurance company, verification of benefits is not a 'guarantee for payment rendered'.
- I agree to pay Curis any outstanding bills that have been denied by my insurance company, and I am aware that uncollected bills over 90 days past due could be sent to an outside collection agency, and/or legal action may be taken. I also understand that Curis reserves the right to bill past due balance for a finance fee, up to 1.5% of that current balance/amount owed.
- I agree to pay Curis any deductible amounts and any copayments that may be affiliated with my insurance plan.
- It is my responsibility to inform Curis of any changes in insurance benefits. If services are rendered during a time of non-coverage, I understand that I am responsible for full payment of services.
- As a patient, it is MY responsibility to understand my insurance policy/limitations. Curis staff will discuss costs and verify benefits as a service to me, however, any services that are rendered as a part of my care, are ultimately my responsibility.

Out of common courtesy to other patients and our providers, please do your very best to be respectful of the time you reserve for appointments. We do our best to remind you of your appointments but ultimately, ***the appointments you make are your responsibility****. Appointment reminders go out 24-48 hours prior.*

<u>Chiropractic</u> - No Show/Failure to Cancel appointment may result in $30 charge to your account.
*****If there is a pattern of no show/failure to cancel, it is up to the discretion of the service provider whether to continue to schedule further appointments. By signing this document you agree to the above terms.*****

Patient Name	Patient Signature	Date

Parent or Guardian Name	Patient or Guardian Signature	Date

Curis Functional Health is an **Integrated Wellness Center**. What does Integrated mean? It means Doctors of Chiropractic, Mental Health Professionals & Dietitians / Nutritionists all working together to provide a greater spectrum of services. This model allows you the convenience of a multi-disciplinary approach without the headache of juggling multiple doctors at multiple locations on multiple schedules. You shouldn't have to put off dealing with one problem while you deal with another. You deserve quick, concise, expert patient care for all of your needs, and you deserve all of those experts working together to know what each other are doing for you and why.

HELP US HELP YOU AND THE ONES YOU LOVE

Here is a list of some of the more common problems that our staff are especially well trained to deal with. Please check those that you or your immediate family suffer from:

_____ Neck Pain

_____ General Chronic Pain

_____ Diabetes / Pre-Diabetes

_____ Parenting Problems

_____ Chronic Fatigue or Difficulty Sleeping

_____ Shoulder Pain or Degeneration

_____ Trigger Points (Knots or Spasms in your Muscles)

_____ Headaches

_____ Difficulty Managing Weight

_____ Medication Management

_____ Difficulty Concentrating

_____ Whiplash

_____ Trouble Coping After Difficult Life Changes

_____ Low Back Pain

_____ Chronic Arthritis

_____ Trouble in Your Relationship(s)

_____ Neuropathy (Arms or Legs)

_____ Knee Pain or Degeneration

_____ Insomnia, Anxiety, Worry, or Panicked

_____ Carpal Tunnel Symptoms

_____ Hip Pain and/or Degeneration

_____ Feeling Down, Depressed, Apathetic

_____ Sciatica

_____ Rotator Cuff Tears or Injuries

_____ Fibromyalgia

_____ Rolled Shoulders or "Humpback"

Other Problems that haven't previously responded to treatment? Please List: _____

Name: _____ Phone: _____ Email:_____

Thank You For Your Trust!

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Curis Functional Health, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

ASSIGNMENT OF MEDICAL BENEFITS & INFORMED CONSENT

- I understand that **my doctor is submitting my x-rays to Midwest Radiology Consultants (MRC) for radiological evaluation**.
- ***Midwest Radiology Consultants does not participate with any health insurance company, including Medicare and Medicaid.***
- **For motor vehicle accidents,** I authorize my insurance company to **pay directly to Midwest Radiology Consultants for services rendered.** In the event that the insurance company sends **payment directly to me**, I agree to **promptly remit such payment to Midwest Radiology Consultants**.
- **Returned checks** for insufficient funds will be assessed a $20.00 service charge.
- ***Accounts delinquent by 90 days from the time of my 1st billing statement may be placed with a legal collection agency. I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.***
- **I agree that I am directly responsible for the charges of any unpaid portion.**

Patient Signature: I have read and understand the above information.

_____

(Patient, Parent or Guardian)

Date: _____

MIDWEST RADIOLOGY CONSULTANTS
704 E Langsford Rd.
Lee's Summit, MO 64063
Phone: 816 525-2822
Doran L. Nicholson, D.C., D.A.C.B.R.

Midwest Radiology Form

P. O. Box 1122
Lee's Summit, MO 64063
Phone: 816 525-2822
Doran L. Nicholson, D.C., D.A.C.B.R.

The fee for radiology read and report by a Board Certified Radiologist is: **$40.00**

Payment may be made by (please check which method you prefer)

☐ **Check (Please include)**

☐ **Please charge my credit card (please include all information below)**

***We accept Mastercard, Visa, Discover and AmExp

CONFIDENTIAL

Date:		**Amount to charge:**	**$40.00**				
Patient Name:		**Phone Contact:**					
Card #:		**Exp. Date**		**Sec Code:**			
Card Holder Name: (if not patient)							
Billing Address:		**Zip:**					

***Midwest Radiology Consultants is an independent radiology service and is not associated with any clinic. The above payment is for evaluation of your x-rays by a radiologist. I authorize Midwest Radiology Consultants to charge my card in the above designated amount.**

Patient Signature: _____ **Date:** _____

☐ **Please mail me a receipt.**

☐ **Please e-mail me a receipt. E-mail Address:** _____
