



Welcome to our office! Please take a few minutes to fill out the following health questionnaire as completely as possible. This will assist the doctor in determining the true cause of any health issues you may be having. With this, and the information gathered during your examination, the doctor will be better able to determine the best course of treatment for you.

Our office is a multi-specialty practice, offering family practice & pain management healthcare, chiropractic physiotherapy, rehabilitation, acupuncture, massage therapy, and nutritional counseling. 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 and doctors to perform any examinations, diagnostic tests and/or treatment as we may consider medically necessary and to release all information pertinent to your health, insurance or benefits to any and 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; religious or political beliefs, quality health services delivered with dignity and concern. HIPAA requires that we have you read and sign the federally governed Health Care Privacy Notice. This Notice is detailed on the last page 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. The Notice is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this signed document by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms and conditions of the Health Care Privacy Notice and all policies, consents, terms and conditions regarding your responsibilities to this Facility. You grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern the operations and responsibilities of this facility. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before and after work as well as during lunch. All missed appointments not made up within 7 days (actual, not business) outside the patient's usual schedule, is subject to a \$25.00 charge. As a courtesy for you, we may call, send an email or letter when an appointment is missed and/or you have not been in for a while. If you do not wish for us to contact you please let us know in writing for your file.

CONFIDENTIAL HEALTH INFORMATION

Dr. Sean Casey, D.C.
 Dr. Kristina Ruddle, D.C.
 314-416-4900
 4455 Telegraph Road, Suite 250
 Saint Louis, Missouri 63129
 www.healthcarecomplete.info

Please allow our staff to photocopy your driver's license and insurance details.
 All information you supply is confidential. We comply with all federal privacy standards.
 Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

No Yes

Whom may we thank for referring you?

When?

If so, whom?

Age **Gender**
 Male Female

Race
 American Indian Alaskan Native Asian Black or African American
 Native Hawaiian Other Pacific Islander Other White
 Decline to answer

Ethnicity
 Hispanic or Latino
 Not Hispanic or Latino
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker Former Smoker
 Current Every Day Smoker Current Some Day Smoker
 Heavy Smoker Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status Married

Single Divorced

Widowed Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

Secondary Complaint

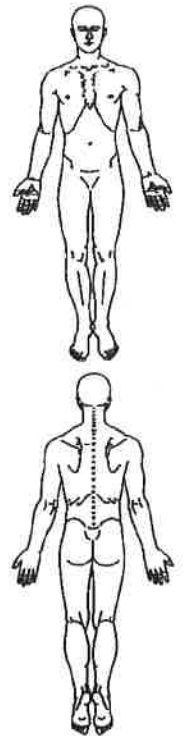
The secondary symptom that prompted me to seek care today is: _____

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

Location

(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

1. What else should Dr. Casey or Dr. Ruddle know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Arthritis | <input type="radio"/> Scoliosis | <input type="radio"/> Neck pain | <input type="radio"/> Back problems | <input type="radio"/> Hip disorders | Initials _____ |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | |

b. Neurological

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Headache | <input type="radio"/> Dizziness | <input type="radio"/> Pins and needles | <input type="radio"/> Numbness | Initials _____ |

c. Cardiovascular

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure | <input type="radio"/> Low blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> Poor circulation | <input type="radio"/> Angina | <input type="radio"/> Excessive bruising | Initials _____ |

d. Respiratory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma | <input type="radio"/> Apnea | <input type="radio"/> Emphysema | <input type="radio"/> Hay fever | <input type="radio"/> Shortness of breath | <input type="radio"/> Pneumonia | Initials _____ |

e. Digestive

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia | <input type="radio"/> Ulcer | <input type="radio"/> Food sensitivities | <input type="radio"/> Heartburn | <input type="radio"/> Constipation | <input type="radio"/> Diarrhea | Initials _____ |

f. Sensory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision | <input type="radio"/> Ringing in ears | <input type="radio"/> Hearing loss | <input type="radio"/> Chronic ear infection | <input type="radio"/> Loss of smell | <input type="radio"/> Loss of taste | Initials _____ |

g. Skin

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer | <input type="radio"/> Psoriasis | <input type="radio"/> Eczema | <input type="radio"/> Acne | <input type="radio"/> Hair loss | <input type="radio"/> Rash | Initials _____ |

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Dr. Sean Casey, D.C.
Dr. Kristina Ruddle, D.C.

(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE
Initials _____

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE
Initials _____

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight gain/loss (circle one) Had Have Weakness NONE
Initials _____

Patient name _____

Patient Number (office use only) _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

- Had Have AIDS Had Have Tuberculosis
 Alcoholism Typhoid fever
 Allergies Ulcer
 Arteriosclerosis Other: _____
 Cancer
 Chicken pox
 Diabetes
 Epilepsy
 Glaucoma
 Goiter
 Gout
 Heart disease
 Hepatitis
 HIV Positive
 Malaria
 Measles
 Multiple Sclerosis
 Mumps
 Polio
 Rheumatic fever
 Scarlet fever
 Sexually transmitted disease
 Stroke

7. Allergies

Are you allergic to any medications?

- Yes No If Yes please list: _____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- Appendix removal
 Bypass surgery
 Cancer
 Cosmetic surgery
 Elective surgery: _____
 Eye surgery
 Hysterectomy
 Pacemaker
 Spine _____
 Tonsillectomy
 Vasectomy
 Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

- Past Currently
 Acupuncture
 Antibiotics
 Birth control pills
 Blood transfusions
 Chemotherapy
 Chiropractic care
 Dialysis
 Herbs
 Homeopathy
 Hormone replacement
 Inhaler
 Massage therapy
 Physical therapy
 Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

8. Injuries

Have you ever...

- Had a fractured or broken bone Used a crutch or other support
 Had a spine or nerve disorder Used neck or back bracing
 Been knocked unconscious Received a tattoo
 Been injured in an accident Had a body piercing

PERSONAL

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Casey or Dr. Ruddle about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Dr. Casey or Dr. Ruddle about your health habits and stress levels.

- Alcohol use Daily Weekly How much? _____ Prayer or meditation? Yes No
Coffee use Daily Weekly How much? _____ Job pressure/stress? Yes No
Tobacco use Daily Weekly How much? _____ Financial peace? Yes No
Exercising Daily Weekly How much? _____ Vaccinated? Yes No
Pain relievers Daily Weekly How much? _____ Mercury fillings? Yes No
Soft drinks Daily Weekly How much? _____ Recreational drugs? Yes No
Water intake Daily Weekly How much? _____
Hobbies: _____

SOCIAL

Doctor's Initials

Dr. Sean Casey, D.C.
Dr. Kristina Ruddle, D.C.

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

Patient Number
(office use only)

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Consultation Notes

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, 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.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **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. Date of last menstrual period (MM/DD/YYYY): _____**

Initials _____ **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.**

Initials _____ **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.**

Initials _____ **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.**

Patient (or Guardian's) signature _____

Date (MM/DD/YYYY) _____

Doctor's Initials _____

Dr. Sean Casey, D.C.
Dr. Kristina Ruddle, D.C.

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 any time 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 licenses 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 be in writing allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or another person. Your provider may charge a copy fee, which will comply 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, unless 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 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 predetermined.

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 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, judgement 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 authorize 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, the Facility 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 & staff are 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. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in additional filing or medical report charges, which you are responsible to pay.
2. Co-payments, 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, judgement, 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 1 1/2% 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 fees. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payment or other reasons of non-payment will be assessed a \$30.00 charge.
7. 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 my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Patient Name

Signature (if minor, parent or legal guardian must sign)

Date

PHI Use and Disclosure Authorization

Healthcare Complete, LLC- 4455 Telegraph Road, Suite 250, Saint Louis, Missouri 63129

I authorize Healthcare Complete to use and disclose my protected health information (PHI):

- Unspecified- This Option Includes All PHI, the designated individual(s) or entity would have full access to protected health information on file at Healthcare Complete.

-or-

- Specify PHI that can be disclosed:

Name of Entity or person(s) to receive information:

Name: _____ Relationship to Patient: _____

Phone Number: () - Email: _____

Address: _____

Name: _____ Relationship to Patient: _____

Phone Number: () - Email: _____

Address: _____

This authorization does not expire unless revoked or terminated by the patient or the patient's personal representative.

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to the office. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that information that is disclosed under this authorization may be disclosed by the recipient as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

Name of Patient or Personal Representative (Print)

Description of Personal Representative's Authority

Signature of Patient or Personal Representative

Date

Witness Name/Signature

Date



healthcarecomplete

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**In order to better communicate with our patients,
please let us know how you found our office information:**

I was referred to Healthcare Complete by my:

Friend/Family Member : _____
Insurance Company Name: _____
Medical Provider's Name: _____
Other: _____

-OR-

I found Healthcare Complete Online: (Circle One)

Google Facebook Twitter Healthpros.com Other: _____

Coming soon!

We plan to make some changes in the way we contact you:

_____ **YES, I would like to opt in to be sent text message reminders of my appointments.**

Cell phone number: _____ () - _____

Phone Carrier: _____

_____ **YES, I would like to opt in to be sent an email reminder of my appointments.**

Email address: _____

Printed Patient Name: _____

Patient Signature: _____ Date: _____