healthcarecomplete

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 physio-therapy, 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.

You 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 direst 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.

PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____ DOB:_____

Case Number:_____ Father's Name:_____ DOB:_____

Address:_____ City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Mother's Work Phone:_____ Mother's Cell Phone:_____

Email:_____ Father's Work Phone:_____ Father's Cell Phone:_____

Birth Date:_____ _____ _____ Age:_____ Sex:_____ Number of Siblings:_____ Referred by:_____

Birth Weight:_____ Birth Length:_____ Current Weight:_____ Current Length:_____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems During Pregnancy:_____

Problems During Labor/Delivery:_____

Apgar Scores:_____ _____ Was there presence at birth of: Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects?_____ If Yes, Please Explain?_____

Infant Feeding: Breast_____ Bottle_____ If Bottle, Which Formula? _____

Number of Hours Sleeping per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor _____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Immunization History:_____

Number of doses of antibiotics your child has taken: During the past six months_____ During his/her lifetime_____

Previous Chiropractor:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Has your child ever been treated on an emergency basis?_____ If yes, please explain:_____

Purpose of this Appointment:_____

Insurance/Billing Information:_____ Policy #:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED:_____ WITNESSED:_____ DATE_____ _____ _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED:_____ DATE_____ _____ _____

PEDIATRIC CASE HISTORY

Delivery/Birth History:_____

_____

_____

_____

At what age did the child:

Respond to Sound_____ Follow an Object with His/Her Eyes_____ Hold Head Up _____

Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____

Has this child ever suffered from:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Colic
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Other_____
- ☐ Other_____

Has this child ever suffered the following spinal traumas?

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from highchair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard or skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

_____

Surgery:_____

Medications:_____

Accidents:_____

Family History:_____

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Child's Name:_____ **Social Security Number:**_____

How does your child's current condition interfere with their:
Sleeping:_____
Eating:_____
Mobility:_____
Temperament:_____
Is your child taking any supplements? _____
What else should Dr. Casey or Dr. Ruddle know about your child's current medical history?

_____

_____

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

_____

If your child has siblings, do any of them have a medical diagnosis?

_____

_____

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

___ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help my child in the restoration of his or her 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.

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

___ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge my child is not pregnant. Date of their last menstrual period, if applicable:_____

___ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information as an extension of my child's care in this office.

___ I acknowledge that any insurance my child may have is an agreement between the carrier and my child and that I am responsible for the payment of any covered or non-covered services he or she receives.

___ 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 child's health concern.

Preferred Method of Contact

- ☐ Home phone
- ☐ Work Phone
- ☐ Cell Phone
- ☐ Email

Parent/Guardian signature:_____ Date:_____

Healthcare Complete, LLC
Kristina Ruddle D.C., LLC
4455 Telegraph Road, Suite 250
St. Louis, MO 63129

CONSENT TO TREATMENT OF A MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize Dr Kristina Ruddle and/or Dr Sean Casey as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization may, in the exercise of his/her best judgement, deem advisable. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above.

In no event shall my signature to any other such document have any effect on this consent form.
The authorization shall remain effective unless revoked in writing delivered to the agent(s) noted above.

Relationship to the minor:

☐ Custodial Parent ☐ Adoptive parent with custody

☐ Guardian by Law. Date Guardianship Commenced: ___/___/___

☐ Other (please specify): _____

Address of Parent/Guardian: _____

_____

Home Phone #: (___) _____ Work Phone #: (___) _____

Name of Custodial Parent/Legal Guardian (please spell clearly): _____

Signature: _____ Date: __/__/__

Witness (if any)

Witness' Name: _____

Witness' signature: _____ Date: __/__/__

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

(314) 416-4900
Fax: (314) 487-4669

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 wilhout 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, it's 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 with 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 1½% 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

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integrated convenient personalized

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 Healthprofs.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:**_____