CHERRY HEALTH CENTER
607 WEST BATTLEFIELD, SPRINGFIELD, MO 65807
(417) 869-2000
FAX: (417) 881-1850

Please Print all Answers

New Patient Information

Name ______ Age ______ Sex ______ Date ______
Street Address ______ City / State ______ Zip ______
Home Phone ______ Work Phone ______ Cell Phone ______
Best time to Call ______ Which # ______ E-mail ______
Social Security # ______ Birthdate ______ Employer ______

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name ______
Family Dr. Name ______ Spouse's Employer ______
Family Dr. Phone ______ Spouse's Birthdate ______
Family Dr. Address ______ Spouse's Social Security ______
Parent's Employer If Patient Is Minor / Child ______
Parents Social Security # If Patient Is Child ______
Emergency: Who Do We Call? ______ Phone ______ Relationship ______
Name of Relative or Friend Not Living with You Phone

REFERRAL INFORMATION

WHO recommended you to our office? ☐ My Doctor ☐ Family / Friend ☐ ______
Name ______ Address or Phone ______

HEALTH INSURANCE INFORMATION

Name of Insurance Company ______ Group Number ______
Name of Insured (Policy Holder) ______ Policy Number ______
Insured Birthdate ______ Relationship to insured ______

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company ______
Agent Name ______ Agent Number ______
Accident Claim Number ______ ______
Name of LIABLE Insurance Company ______ Phone Number ______
Claim Number ______ Insured's Name ______
Attorney Name ______ Phone Number ______

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party ______ Claim # ______
Contact Person ______ Phone Number ______

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical

Welcome to our multi-specialty group practice, offering pain management medical care, chiropractic, physical therapy, & rehabilitation. 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 & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & 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 or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -4- 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 and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just 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 & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that 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 this Facility operations and responsibilities. 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 & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $15.00 as a missed appointment fee that you must pay before you are seen or treated again. 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.

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Patient Name: ______________________ DOB: ____________

SYMPTOM SURVEY

What is your chief problem or symptoms? ______________________
What caused the problem or symptoms to occur? ______________________
When did the problem or symptoms begin? ______________________
Have you seen another doctor for this problem? □ No, If yes, who ______________
What tests/procedures have been performed? □ X-Ray □ MRI □ Surgery □ Hospitalization □ ________
Have you had this problem or symptoms in the past? □ No, If yes, explain ______________
Have you tried any other treatments for this? □ No, If yes, explain ______________
Is the problem or symptoms getting worse? □ No, If yes, explain ______________

FEMALE PATIENTS (for imaging purposes)
Last menstrual period: ______________________ Is there a chance you could be pregnant? ❑ Yes ❑ No

MEDICAL/FAMILY HISTORY **S = Self M = Mother F = Father**
(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble ________	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer ________	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Past surgeries: ❑ Yes ❑ No
❑ Appendectomy ❑ Heart ❑ Hysterectomy ❑Lower Back
❑ Mastectomy ❑ Neck ❑ Tonsillectomy
❑ Other surgeries not listed above:______________________________________
____

Social History:

Alcohol Usage:	❑ none	❑ light	❑ moderate	❑ heavy
Drug usage:	❑ none	❑ light	❑ moderate	❑ heavy
Exercise:	❑ never	❑ seldom	❑ occasional	❑ regularly
Tobacco Usage:	❑ none	❑ light	❑ moderate	❑ heavy

Preferred language (spoken & written) ❑ English ❑ Spanish ❑ ____________
Race ❑ Caucasian ❑ African-Am ❑ ____________
Ethnicity ❑ Hispanic ❑ Non-Hispanic ❑ Declined
Occupation ______________________ ❑ Full Time ❑ Part Time
Employment Status ❑ Working ❑ Sick Leave ❑ Unemployed ❑ Retired
❑ Temp Disability ❑ Perm Disability Last Day of Work ____________

List all drug / chemical / latex / iodine **allergies** ______________________________________

List all **current** medications / drugs ______________________________________
____
____
____

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Patient Name: ________________________________ DOB: _______________

PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

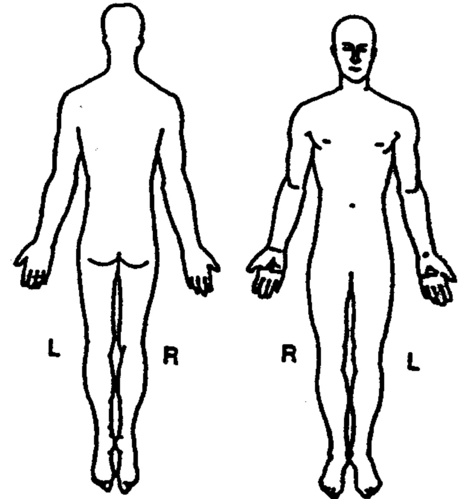
Pain	: : : : : : : : : :
Numbness	+ + + + + +
Burning	/ / / / / / / / / /
Ache	X X X X X X

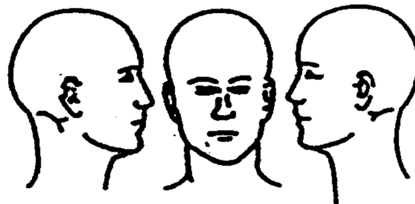
Describe your pain (check all that apply):

- □ Constant
- □ Intermittent
- □ Recurring
- □ Stabbing
- □ Dull Ache
- □ Sharp
- □ Deep Ache
- □ Throbbing
- □ Tingling
- □ While Resting
- □ Daily
- □ During Exercise
- □ Nightly
- □ ____________________

Cause of Pain:

- □ Traumatic __________
- □ Chronic ____________
- □ Post Surgical
- □ Work Related
- □ Motor Vehicle
- □ Unknown





Onset of Pain:

- □ Sudden
- □ Gradual

On a scale of 1 to 10 how would you rate your pain level? ________ (1 = Mild, 10 = Intense)

What if anything gives you relief? ____

What if anything makes the pain worse? ____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

□ **AUTO ACCIDENT** Date __________ Time ____ [am] [pm] Location ______________________________

Were You

- □ Driver □ Passenger
- □ Unconscious □ Treated in E.R.
- □ Wearing a Seat Belt □ YES □ NO
- □ Transported by Ambulance □ YES □ NO

Vehicle Damage □ Minimal – Moderate □ Severe - Totaled

Was the vehicle towed away? □ YES □ NO

Police Report □ None □ Yes with Police Dept___________________________

Activities □ No restrictions □ Missed ____ days of work or school

□ I felt fine before the accident

□ **WORK RELATED** Date __________ Time ____ [am] [pm] Location ______________________________

Describe injury and how it happened:

____

____

____

Accident Reported to ____________________________________ on ____________(date)

□ No restrictions □ Missed ____ days of work or school

□ I felt fine before the injury

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CHERRY HEALTH CENTER 417-869-2000
607 WEST BATTLEFIELD, SPRINGFIELD, MO 65807 FAX: 417-881-1850

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 anytime 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 licensed 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 in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance 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, except in the event that 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 the 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 pre-determined.

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 course of 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 hereby release Cherry Health Center, LLC from liability for any adverse effects that may arise from undergoing diagnostic imaging at this time if I am subsequently found to have been pregnant and I assume responsibility for my decision to undergo this procedure. If there is a possibility I am pregnant, I will make this known and will inform the technologist before the examination

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, judgment 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 authorizes 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 an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, 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, judgment, 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 fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.

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 of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

______________________________ ______________
Print Name of Patient Date of Birth

X_____________________________ ______________
Signature (relationship if minor) Date

Cherry Health Center
607 W Battlefield Rd, Springfield MO 65807

Phone: 417-869-2000
Fax: 417-881-1850

Confidentiality is very important to us. Our standard policy, unless you tell us otherwise, is not to provide any information. Equally important is patient service and service to family and other loved ones. Often family members inquire about health status or wish to be involved in the patient's treatment. Sometimes age specific conditions require that a family member or other loved one, help you with your healthcare. You may provide a release of information that clarifies and allows us to discuss your healthcare with family or other loved ones. You may be selective in this decision as to whom the information is given. By planning in advance misunderstandings can be prevented.
We ask that you please list any emergency contacts on this form and select what information they may have.

I authorize:

▢ Any aspect ▢ Health **only** ▢ Financial **only** ▢ Emergency **only**

NAME	RELATIONSHIP	PHONE

____ I authorize Cherry Health Center to **GIVE** to my primary healthcare provider any and all information regarding my healthcare, personal observations, and concerts and to **RECEIVE** any and all information from my primary healthcare regarding my healthcare status, treatment plans, and prognosis.

______________________________ ______________________________
Patient DOB

____
Authorization to sign if not patient

______________________________ ______________________________
Witness Date

CHERRY HEALTH CENTER
607 WEST BATTLEFIELD, SPRINGFIELD, MO 65807

417-869-2000
FAX: 417-881-1850

Patient Rights & Responsibilities Consent to Privacy Practices

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patient's care, may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. The patient should promptly notify Cherry Health Center of any equipment failure or damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify Cherry Health Center in such instances.
3. The patient should promptly notify Cherry Health Center of any changes to their address or telephone.
4. The patient should promptly notify Cherry Health Center of any changes concerning their physician.
5. The patient should notify Cherry Health Center discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

Consent to Privacy Practices of Cherry Health Center **Effective Date: October 22, 2008**

You have been provided with a copy of Cherry Health Center's "Notice of Privacy Practices" that describes how we will use health information concerning our service to you. The notice details how we will use this information to provide treatment care for you, to gain reimbursement for our services and to improve our operations to better serve you and other patients.

__________ I wish to receive a paper copy of Cherry Health Center's "Notice of Privacy Practices".
__________ I do not request a copy of Cherry Health Center's "Notice of Privacy Practices" at this time. I acknowledge that I may request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regards to my rights, I may speak with the Privacy Officer about my concerns.

We are required to document that:

- We have given you our Notice of Privacy Practices and that you have had the opportunity to review it;
- Cherry Health Center will notify you of changes in our Notice of Privacy Practices prior to implementing those changes;
- You may request restrictions as to how your health information may be used although Cherry Health Center is not required to agree to those restrictions;
- Any restrictions to which Cherry Health Center agrees to will be respected.
- You may revoke this consent in writing at any time, although Cherry Health Center can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that take place before the consent was revoked.

Please provide your signature below to indicate understanding and consent for use of health information related to our service.

____________________________________ ____________________________ ____________
Signature of Patient or Legal Representative Witness Date

Patient Name: ____ DOB: ___________________________

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Cherry Health Center
607 W Battlefield, Springfield MO 65807
phone:(417)869-2000
fax:(417)881-1850

I, ___________________________, hereby consent and state my preference to have my physician, _________________________, and other staff at Cherry Health Center communicate with me by email or standard SMT/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill in the ones that you agree to):

Phone number ________________________________

Email ____

Text ____

I give permission to contact me, relative to appointment REMINDERS ONLY, by the following methods (please fill in the ones that you agree to):

Phone number ________________________________

Email ____

Text ____

____________________________________ ____________________________

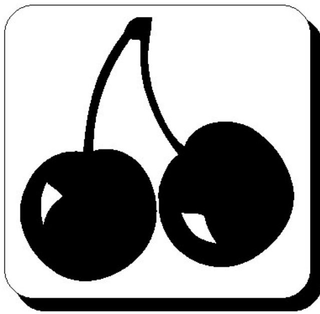
Patient Signature Date

____

Witness / CHC Staff

Patient Name:_____________________________ DOB:__________________

Patient Initials __________



CHERRY HEALTH CENTER
607 W. BATTLEFIELD RD. SPRINGFIELD, MO 65807
(417) 869-2000 Fax: (417) 881-1850
Philip L. Loyd, Chiropractic Physician
Michael J. Koban, Chiropractic Physician
Maria A Carter, D.O.
Zach Rust, DPT

Medicare Meaningful Use Questionnaire
Please answer to the best of your ability

Name: ________________________ DOB: _________________ Date: ______________

Screening for High Blood Pressure

Have you been diagnosed with hypertension (high blood pressure) in the past: YES NO

If yes, do you take medication for high blood pressure? YES NO

Falls: Screening for Future Fall Risk if over the age of 65

Have you fallen 2 or more times within the last year? YES NO

Did any of your falls result in an injury? YES NO

Pneumonia Vaccination Status for Older Adults, 65 years or older

Have you had a Pneumonia Vaccination in the last 10 years? YES NO

Approximate date you received the shot? __________________________________

What facility administered the injection? __________________________________

Preventive Care and Screening: Tobacco Use

Have you ever used tobacco products? YES NO

If yes, do you currently use these products? YES NO

If you no longer use tobacco products, please provide an approximate quit date: _______

Please provide a current list of daily medications with the drug name, dose, and frequency.