YOST Family Chiropractic
3993 100th Street • Urbandale, IA 50322 • 515.278.YOST
www.YostFamilyChiropractic.com

Name: _____ Date: _____ Referred By: _____
Address: _____ City: _____ State: _____ Zip code: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Date of Birth: _____ Age: _____ Gender: _____
Employer: _____ Occupation: _____ Work Phone: _____
Marital Status: M S W D Spouse: _____ Occupation: _____
Number of Children, Names & Ages: _____
Primary Care Physician: _____ Clinic Name: _____
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care here? Y N
Primary Insurance: _____ Secondary Insurance: _____

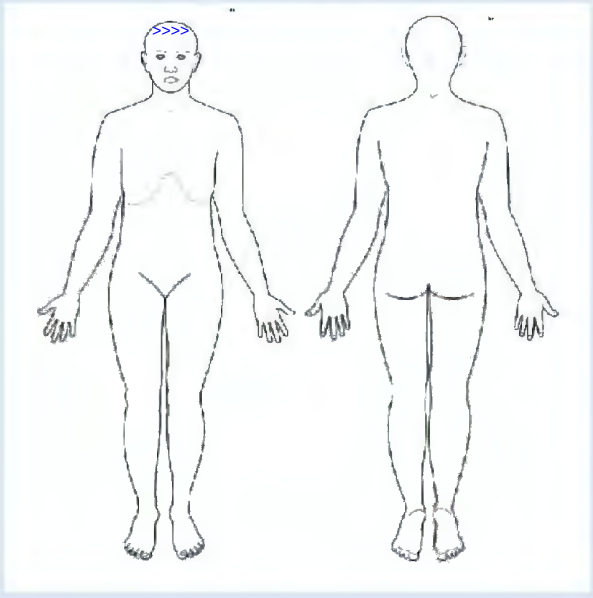
Demographics: Language _____ (Primary)
Race: Unspecified _____ American Indian or Alaska Native _____ Black or African American _____ Other _____ White _____
Ethnicity: Not Hispanic or Latino _____ Hispanic or Latino _____ Unspecified _____
Would you like reminders for future appointments? If so, ☐ TEXT, ☐ EMAIL, or ☐ NONE? (Circle One) * **Phone Carrier** _____

History of Present Illness

Is your visit for wellness care? Y N If yes, skip to **Past Medical History**
Chief Complaint: _____
Date symptoms began: _____ Due to: Auto Work Other: _____
Have you experienced similar symptoms before? Y N If yes, when? _____

Indicate where & type of pain

Ache >>>>
Numb ====
Pins & Needles ooo
Burn XXX
Stabbing ////
Throbbing ~~~
Radiating Pain, use arrows



DOCTOR USE ONLY

Setting: AM ☐
MIDDAY ☐
PM ☐

Progression: WORSE
BETTER ☐
SAME ☐

CONSTANT _____
COME & GO _____

Please Rate your current pain:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable
What makes this pain worse: _____ What makes this pain better _____

Have you seen any other health care providers for this complaint? Y N If yes, who: _____
Results: _____ Were X-Rays or other imaging taken? _____

Please check any of the following activities which the pain affects:

☐ Lying on back
☐ Lying on side
☐ Turning over in bed
☐ Getting in/out of car
☐ Lying flat on stomach
☐ Gripping
☐ Reaching
☐ Climbing stairs
☐ Dressing Self
☐ Sexual activity
☐ Pushing
☐ Kneeling
☐ Sleeping
☐ Sitting
☐ Walking
☐ Bending forward
☐ Standing for >1hr
☐ Cough/Sneeze/Grunt

Past Medical History

Please list all injuries, major illnesses, surgeries, falls, auto accidents, or hospitalizations

Injury/Illness	Date	Treatment	Residual Symptoms
1.			
2.			
3.			
4.			
5.			

Have you ever had chiropractic, acupuncture, or massage therapy care? Which one(s)? _____

When: _____ With whom: _____

What were the results?: _____

Please check each of the conditions you have currently, or have had in the past:

- ☐ Blurred Vision
- ☐ Light sensitivity
- ☐ Ringing of ears
- ☐ Congested Sinus
- ☐ Headaches
- ☐ Loss of balance
- ☐ Fainting
- ☐ Neck pain
- ☐ Thyroid
- ☐ Difficulty Breathing
- ☐ Chest pain
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Cancer
- ☐ Low Back pain
- ☐ Shoulder/Arm pain
- ☐ Pain between shoulders
- ☐ Arthritic pain
- ☐ Ulcers/Colitis
- ☐ Allergies
- ☐ Asthma
- ☐ Numbness
- ☐ Digestive problems
- ☐ Heartburn/Indigestion
- ☐ Loss of sleep
- ☐ Knee/Foot pain
- ☐ Swelling
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Loss of Appetite
- ☐ Unexplained weight loss
- ☐ Excessive thirst
- ☐ Irregular Menstrual flow
- ☐ Hot flashes
- ☐ Breast soreness/lumps
- ☐ Loss of bladder control
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Constipation
- ☐ Dermatitis/Eczema/Rash
- ☐ Depression
- ☐ Blood disorder
- ☐ Bladder Infection
- ☐ Gallbladder/Kidney Problems

Please list any current medications or supplements: _____

_____

Date of last (gynecological/breast) or (testicular/prostate) exam: _____ Was everything normal? Y N

Please circle if you have a family history of:

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Stroke ☐ Epilepsy ☐ Migraines ☐ Back pain

Social Health History

How many hours a week do you work?_____ Do you enjoy your job? Y N Hours of sleep per night:_____

Do you exercise? Y N How often?_____ Type of exercise: _____

Do you drink caffeine? Y N Amount per week:_____ Do you drink Alcohol? Y N Amount per week: _____

Do you use tobacco? Y N #___per: day week (circle one) How much water do you drink per day?_____

I certify the information provided is accurate to the best of my knowledge. I authorize the doctor to examine and treat my condition as she deems appropriate through the use of chiropractic care.

Patient Signature: _____ Date: _____

Informed Consent:

CHIROPRACTIC: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the name of the patient below, for whom I am legally responsible for) by Dr. Yost and/or other licensed doctors of chiropractic who now or in the future with at Yost Family Chiropractic Inc.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to reply upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts that known to him or her, is in my best interest. I understand that results are not guaranteed. I have read the above consent. I understand I have the opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information. *(Request a copy if needed.)*

ACUPUNCTURE: Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation near the needle. Patients usually report little or no pain during an acupuncture treatment.
Side Effects: The following side effects may occur and are not limited to the following:

a. Some pain following treatment in the insertion location (uncommon).
b. Minor bleeding from insertion location (occasionally).
c. Minor bruising (occasionally).
d. Infection (rare).
e. Needle sickness (feeling faint or dizzy, rare).
f. Broken needle (almost unheard of).

(Not to mention are many other potential side effects of treatment which are much more common: acquisition of a deeply relaxed state, drugless relief of your condition, enhanced well being, improved immunity and increased mental clarity and insight.)

Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient.

MASSAGE: I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massageon anyone whom she deems to have a condition for which massage is contraindicated.

With this knowledge, I give my informed and voluntarily consent to the above procedures:

Print Patient Name: _____ Date:_____

Patient or Guardian Signature: _____

Authorization, Release & Financial Polices:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of my insurance coverage.

I understand and agree to allow this chiropractic office to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. The following person(s) have my permission to receive my personal health information: _____ _____

I do understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for services provided to me by the chiropractor. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card given at time of check in. If payment hasn't been received in 10 days from terminating any care, I authorize deduction from my credit card.
PLEASE NOTE: Insurance companies do not pay for care that is not medically-necessary. If your child does not have a musculoskeletal complaint, he/she does not qualify for insurance coverage.

Print Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

PERSONAL WELLNESS GOALS AND SOCIAL HISTORY:

Please list the 5 major health concerns or health goals in your order of importance:

1

2

3

4

5

When was the last time you were completely healthy? You felt alive? You felt everything was moving in the right direction?

What do you think happened that caused you to start to feel unhealthy or not 100%7 (it could be emotional, it could be physical etc.)

How often do you have bowel movements?

☐ D 2-4x a day ☐ D 1x a day ☐ 1 x every other day ☐ Less than 1 x every other day

Besides your spouse, your kids, your parents and your job, what do you love, what is your passion, what is the one thing you enjoy the most to do?

DIETARY HABITS:

Do you skip meals? ☐ Yes ☐ No

Do you consume coffee or other beverages like energy/diet drinks, or colas daily? ☐ Yes ☐ No

If yes, how many servings per day?

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

-You may request restrictions on your disclosures.
-You may inspect and receive copies of your records within 30 days with a request
-You may request to view changes to your records
-In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
-Obtain payment from third party payers
-Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand the Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request in writing, that you restrict how my personal information is used and or disclosed.

Printed Child's Name: _____

Patient/Guardian Signature: _____ Date: _____

Using Health Insurance?

Because your insurance policy is an agreement between you and that particular company, we ask that you call and determine what your benefits are. Please use this form to assist you in getting your questions answered and helping you understand your chiropractic benefits. Feel free to ask your insurance representative any additional questions you may have.

1. Call the Customer Service/Member # on your insurance card. Follow the automated steps to receive your member benefits.

2. What is Insurance Representatives name: _____

   a. Date: _____ Time: _____

3. My name is _____; I am calling to see what my chiropractic benefits are.

4. I will be seeing Dr. Heather Yost with Yost Family Chiropractic. Is she in or out of network?

5. Is there a deductible? {YES} {NO} (circle one)

   a. If YES, what is my deductible amount? _____

   b. How much has been applied to my deductible? _____

6. What are my chiropractic benefits?

   a. Co-Insurance: _____

   b. Copay: _____

7. Are there any policy limitations such as a dollar amount or number of office visits? _____

_____

   a. If YES, has anything been already applied to these limitations? _____

8. What is my policy period? (example: calendar year) _____

9. Is authorization and/or referral required for my plan? _____

10. Are my covered benefits based on medical necessity? {YES} {NO} (circle one)

11. Provide your insurance representative with the following codes. Find out if they have the same chiropractic benefit quoted above or if they have a separate benefit.

   a. Are x-rays covered, if done in the office? _____

   b. CPT Code 99202 (Exam): _____

   c. CPT Code 97014 (Muscle Stimulation Therapy,): _____

   d. CPT Code 97112 (ART, Muscle Therapy): _____

   e. CPT Code 29200 (Kinesotape Strapping): _____

Consultations are free of charge and all fees will be discussed before any services are rendered

PS – Have an HSA or FLEX account? Great news! Take advantage of reduced fees *(sometimes even better than your insurance benefits!)* by using these tax savings accounts.

Patient Print Name: _____

Patient Sign: _____ Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of (●) Parent/( ) Guardian (circle one)

Missed Appointment Policy

Thank you for choosing Yost Family Chiropractic for your health & wellness care. As a client of this practice, please know that we will strive to give you the best care. To accomplish our goal and meet your needs, the following policy applies:

You are responsible for providing a valid credit card number in order to schedule any appointment, including chiropractic, massage, and acupuncture, with Yost Family Chiropractic. This credit card guarantees your appointments with YFC and you will not be charged unless you fail to attend your appointment or do not give us at least 24-hour notice to reschedule. A failure to comply with this policy will result in your card being charged for a $30 appointment fee. For your convenience, we accept all major credit cards.

I understand and agree to the above policy. By signing below I authorize deduction from my credit card on file if I fail to follow this policy.

Printed Name: _____ Date: _____

Signature: _____