Southwest Chiropractic and Wellness, PA
306 W. Santa Fe Trail Blvd., PO Box 213
Lakin, KS 67860
p 620.355.4116
f 620.355.4117
southwestchiro.medicfusion.com

Patient: ______________________________________

Authorizations and Releases

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _________

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _________

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _________

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _________

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Initial _________

Signature ______________________________ Date _____________

www.medicfusion.com

eForms courtesy of Medicfusion. Available on the web 24/7.
The Medicfusion logo and all related indicia are trademarks of,
and ©2009 by Medigeek, llc. | All rights reserved.

SOUTHWEST CHIROPRACTIC AND WELLNESS

306 West Santa Fe Trail Blvd.
Lakin, Kansas 67860
[p] 620.355.4116
[f] 620.355.4117
DoctorRiedl@gmail.com

PATIENT PROFILE:

NAME: ____
[FIRST] [M.I.] [LAST]

NICKNAME: ______________________________

SEX: ☐ MALE ☐ FEMALE

DATE OF BIRTH: ______________________

SSN: ______________________________

PHONE: ______________________ [H / M / W] ______________________ [H / M / W]
[PRIMARY] [SECONDARY]

HOW DID YOU HEAR ABOUT US? ____________________________

EMAIL ADDRESS: ____

HOME ADDRESS: ____

____

MAILING ADDRESS: ______________________________________

____

EMERGENCY CONTACT

________________________________ _________________ _______________________ [H / M / W]
[NAME] [RELATIONSHIP] [PHONE]

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO

WHO IS YOUR PRIMARY HEALTH CARE PROVIDER?

________________________________ ________________________________
[NAME] [PHONE]

RESPONSIBLE PARTY? [YOU OR OTHER] ____

PERSONAL HEALTH INFORMATION MAY BE COMMUNICATED IN THE FOLLOWING WAY:

☐ NO PREFERENCE ☐ IN PERSON ☐ OTHER

SOUTHWEST
CHIROPRACTIC AND WELLNESS

306 West Santa Fe Trail Blvd.
Lakin, Kansas 67860
[p] 620.355.4116
[f] 620.355.4117
DoctorRiedl@gmail.com

CHIEF COMPLAINT FORM:

DESCRIBE THE REASON FOR YOUR VISIT: ____

WHEN DID YOUR SYMPTOMS BEGIN? [DATE]: ___________________________

WHAT WORD BEST DESCRIBES THE FREQUENCY OF YOUR SYMPTOMS ?[PERCENTAGE OF AWAKE TIME]:

- ☐ CONSTANT [75%-100%]
- ☐ FREQUENT [51%-75%]
- ☐ INTERMITENT [26%-51%]
- ☐ OCCASIONAL [0%-25%]

WHICH PHRASES BEST DESCRIBE CHANGES IN YOUR SYMPTOMS DURING THE DAY? [SELECT 1 OR MORE]:

- ☐ WORSE IN THE MORNING
- ☐ IT CHANGES WITH THE WEATHER
- ☐ WORSE IN THE AFTERNOON
- ☐ IT DOES NOT CHANGE
- ☐ WORSE AT NIGHT

WHAT HELPS RELIEVE YOUR SYMPTOMS?:

- ☐ ICE
- ☐ HEAT
- ☐ OTHER: ____
- ☐ MEDICATION
- ☐ NOTHING

WHAT ACTIVITIES ARE LIMITED BY YOUR SYMPTOMS? [SELECT 1 OR MORE]

- ☐ BENDING
- ☐ BOWEL MOVEMENTS
- ☐ COUGHING
- ☐ DAILY ROUTNE
- ☐ DRIVING
- ☐ GETTING UP
- ☐ LIFTING
- ☐ LYING DOWN
- ☐ PULLING
- ☐ PUSHING
- ☐ READING
- ☐ SITTING
- ☐ SLEEPING
- ☐ SNEEZING
- ☐ STANDING
- ☐ TURNING MY HEAD
- ☐ URINATION
- ☐ WALKING
- ☐ WORKING
- ☐ OTHER [DESCRIBE]: ____

FOR WOMEN ONLY

ARE YOU PREGNANT? YES / NO MOST RECENT MENSTRUAL CYCLE:____________________________

MEDICAL EXAM HISTORY

- ☐ PHYSICAL EXAM [DATE]: _______________
- ☐ SPINAL XRAY [DATE]: __________________
- ☐ MRI [DATE]: __________________
- ☐ CT SCAN [DATE]: ______________
- ☐ OTHER SCANS OR XRAYS [TYPE & DATE]: ____

HAVE YOU TRIED OTHER MEDICAL TREATMENTS FOR THIS CONDITION? [IF YES, NAME OF PHYSICIAN]:

____

_____ I AUTHORIZE THIS FACILITY TO RELEASE MY RECORDS TO SOUTHWEST CHIROPRACTIC AND WELLNESS.

ARE YOUR SYMPTOMS THE RESULT OF AN ACCIDENT? YES / NO

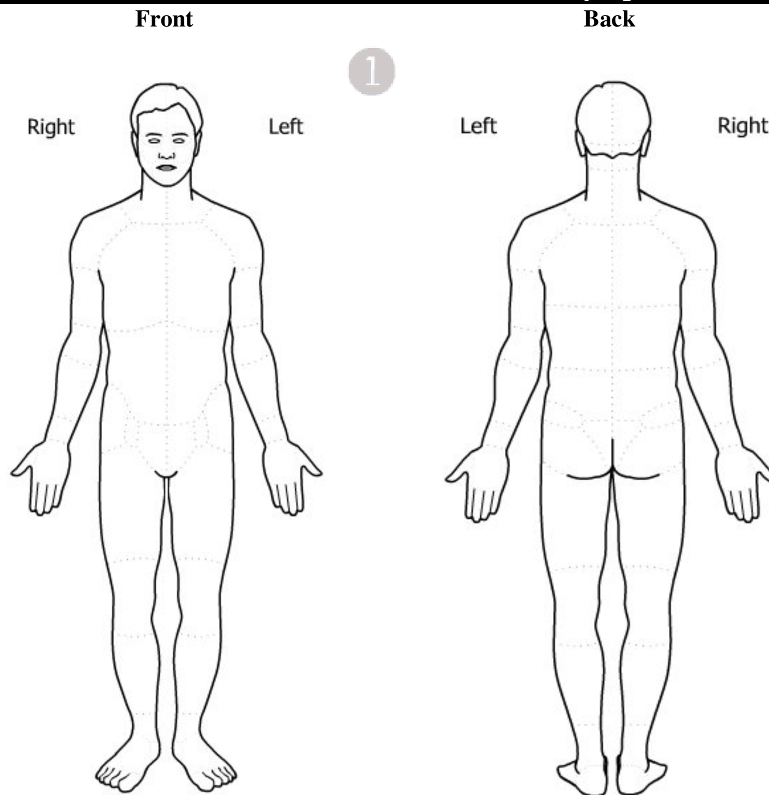
SOUTHWEST CHIROPRACTIC AND WELLNESS

Southwest Chiropractic and Wellness, PA
306 W. Santa Fe Trail Blvd., PO Box 213
Lakin, KS 67860
p 620.355.4116
f 620.355.4117
southwestchiro.medicfusion.com

Patient: ________________________________

Patient Symptom Illustrator

Patient Symptom Illustrator



Instructions:

1 Identify your areas of discomfort by marking the affected body parts in the illustration.

2 Indicate the area name along with your specific symptoms associated with each selected area.

3 Rate your discomfort associated with each selected area.

2

3

0 = No Discomfort 10 = Severe Discomfort

	Area	Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	Rating
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 X 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10

www.medicfusion.com

eForms courtesy of Medicfusion. Available on the web 24/7.
The Medicfusion logo and all related indicia are trademarks of,
and ©2009 by Medigeek, llc. | All rights reserved.