

**Health Quest Physicians Group**  
**3349 American Avenue, Jefferson City, MO 65109**  
**(573) 635-9655**

**NEW PATIENT INFORMATION**

PLEASE PRINT & FILL IN ALL BLANKS

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
FAMILY DR \_\_\_\_\_  
HEALTH INSURANCE \_\_\_\_\_

STATUS: ( )MARRIED ( )SINGLE ( )SEP ( )DIV  
SPOUSESNAME \_\_\_\_\_  
SPOUSES BIRTHDATE \_\_\_\_\_  
SPOUSES SSN \_\_\_\_\_  
SPOUSES EMPLOYER \_\_\_\_\_  
PARENT SSN IF PT IS A MINOR \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_  
PHONE \_\_\_\_\_ RELATION \_\_\_\_\_  
WHO REFERRED YOU TO OUR OFFICE \_\_\_\_\_

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Welcome to our clinic. This is a multi-specialty group practice, offering family practice & pain management care, chiropractic, physical therapy, rehabilitation & nutritional counseling. Our doctors and staff work in partnership with our patients with a goal of coordinated care, health care excellence and high patient satisfaction. 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 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 and/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, 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 2 of this document. The Health Care Privacy Notice will explain where, when and why your confidential health information may be used, stored and/or shared as part of this document which is a permanent part of your medical records which are 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 the policy, 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 question or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstanding. Office hours allow our patients convenience to schedule appointments before and 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 \$20.00 as a missed appointment fee which you must pay before you are seen or treated again. We are available to immediately see new patients the same day. 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.

-please proceed to page 2-

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## HEALTH CARE PRIVACY NOTICE

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This office is committed to providing patients with quality care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patients working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to this clinic.

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. A 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 or (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 concerns 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 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 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.

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## INFORMED CONSENT

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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, nutritional counseling & physical therapy there are some risks including but not limited to fractures, disk injury, strokes, dislocation, 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.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of this Facility.

-please proceed to page 3-

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**ASSIGNMENT OF BENEFITS – AUTHORIZATION LIEN**

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I the assignee, being the patient or legal guardian for said minor, listed below, do hereby irrevocably authorize, direct, assign and give a lien to Health Quest Physicians Group, 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 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 and 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, adjustor, 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.

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**INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS**

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1. As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote 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.
2. 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 medical report charge which you are responsible to pay.
3. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
4. Patients are responsible for charges on all services(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.
5. 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, and services rendered to the patient or minor shown below.
6. 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 and ointments.
7. A service charge is computed by a ‘periodic rate’ of 1 ½% per month-18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more will 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, 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 payment or other reasons or non-payment will be assessed a \$20.00 charge.
8. Please ask any questions you may have regarding your bill and/or fee’s to our insurance & billing department. We do not want any misunderstandings regarding your bill, obligation to pay or terms of when payment is due. For your convenience we accept most major debit & credit cards.

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**PATIENT CONSENT & SIGNATURE**

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By my signature below I acknowledge that I have read or had read to me and have received a photocopy upon by 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.

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**Print Name of Patient**

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**Witness Signature**

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**Signature (if minor, parent must sign)**

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**Date**

# PAIN CHART

## ABOUT YOU

Name: \_\_\_\_\_ File #: \_\_\_\_\_

What is your current weight: \_\_\_\_\_ lbs., and height, \_\_\_\_\_ Ft. \_\_\_\_\_ In..

Please describe your condition:

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness  
Symbol → NNNN

Pins & Needles  
PPPP

Burning  
BBBB

Aching  
AAAA

Stabbing  
SSSS

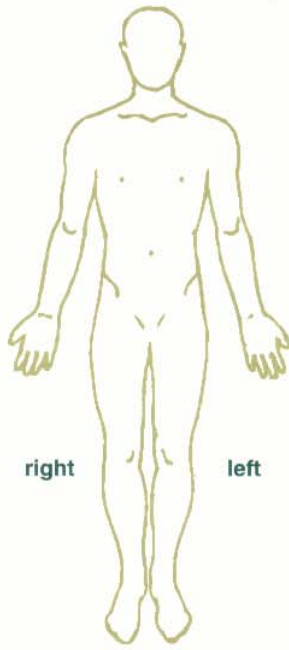
○ Circle any area of pain not represented by a symbol.



Example



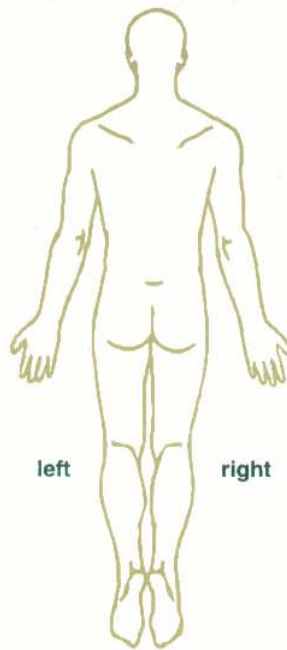
Right



right

left

Front



left

right

Back



Left

## DOCTOR'S NOTES

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET 

First Impression Forms, Inc. 1-800-99FORMS FORM # 2CHIRO.3 © 1996

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**(573) 635-9655**

**ACTIVITIES OF DAILY LIVING EVALUATION**

Patient Name	Account	Date
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Please assist us in evaluation how your condition is affecting your activities of daily living by answering this questionnaire

Activities of Daily Living	Able to perform	Able to perform w/difficulty	Unable to perform	Not applicable	Comments
Rolling over in bed					
Getting in or out of bed					
Getting in or out of bathtub					
Getting dressed and putting on socks					
Showering, bathing, brushing hair/teeth					
Eating or preparing meals					
Walking on flat surface					
Standing for prolonged periods					
Sitting for prolonged periods					
Sleeping for prolonged periods					
Toileting – getting on or off toilet					
Climbing stairs					
Making your bed					
Dusting and light cleaning					
Vacuuming and moderate cleaning					
Gardening and heavy cleaning					
Laundry and ironing					
Washing dishes					
Washing your automobile					
Mowing the grass or snow shoveling					
Lifting loads of 10 pounds					
Lifting loads of 25 pounds					
Pushing loads of 10 pounds					
Pushing loads of 25 pounds					
Pulling loads of 10 pounds					
Pulling loads of 25 pounds					

Signature \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH HISTORY EVALUATION**

Patient Name	Account	Date
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The following are conditions associated with the spine and the nervous system. Please circle if you've had the problem within the last 6 months (now), in the past (past) or circle both if applicable. Please leave the lines out to the side blank for physician comments.

1. (now, past) HEADACHES..... exp. \_\_\_\_\_
2. (now, past) DIZZINESS..... exp. \_\_\_\_\_
3. (now, past) BLURRED VISION..... exp. \_\_\_\_\_
4. (now, past) LOSS OF CONCENTRATION..... exp. \_\_\_\_\_
5. (now, past) DEPRESSION..... exp. \_\_\_\_\_
6. (now, past) NERVOUSNESS..... exp. \_\_\_\_\_
7. (now, past) DIFFICULTY SLEEPING..... exp. \_\_\_\_\_
8. (now, past) LOSS OF ENERGY..... exp. \_\_\_\_\_
9. (now, past) TIRED IN THE MORNING..... exp. \_\_\_\_\_
10. (now, past) BUZZING RINGING IN THE EARS..... exp. \_\_\_\_\_
11. (now, past) FEELING RUN DOWN ..... exp. \_\_\_\_\_
12. (now, past) FAINTING ..... exp. \_\_\_\_\_
13. (now, past) HEART PALPITATIONS ..... exp. \_\_\_\_\_
14. (now, past) SINUS PROBLEMS ..... exp. \_\_\_\_\_
15. (now, past) ANY OTHER HEAD RELATED  
 (EYES, EARS, NOSE OR THROAT) .... exp. \_\_\_\_\_
16. (now, past) NECK PAIN OR STIFFNESS ..... exp. \_\_\_\_\_
17. (now, past) SHOULDER PROBLEMS ..... exp. \_\_\_\_\_
18. (now, past) UPPER BACK ..... exp. \_\_\_\_\_
19. (now, past) MID BACK ..... exp. \_\_\_\_\_
20. (now, past) LOW BACK ..... exp. \_\_\_\_\_
21. (now, past) HIP ..... exp. \_\_\_\_\_
22. (now, past) LEG PAIN OR CRAMPS ..... exp. \_\_\_\_\_
23. (now, past) CHEST PAIN ..... exp. \_\_\_\_\_
24. (now, past) LUNG ..... exp. \_\_\_\_\_
25. (now, past) HEART ..... exp. \_\_\_\_\_
26. (now, past) STOMACH ..... exp. \_\_\_\_\_
27. (now, past) INDIGESTION ..... exp. \_\_\_\_\_
28. (now, past) BLADDER ..... exp. \_\_\_\_\_
29. (now, past) LIVER ..... exp. \_\_\_\_\_
30. (now, past) KIDNEY ..... exp. \_\_\_\_\_
31. (now, past) COLON ..... exp. \_\_\_\_\_
32. (now, past) CONSTIPATION ..... exp. \_\_\_\_\_
33. (now, past) POOR CIRCULATION ..... exp. \_\_\_\_\_

**Please answer the following.**

- 1.) List any hospitalizations or surgeries during your lifetime (with approximate dates) \_\_\_\_\_  
 \_\_\_\_\_
- 2.) List any trauma, auto accidents or major falls during your lifetime (with approximate dates) \_\_\_\_\_  
 \_\_\_\_\_
- 3.) Are you currently on any prescription medication? Please specify. \_\_\_\_\_
- 4.) Does anyone in your immediate family have back or neck problems? (i.e. mother, father, brother, sister) Please list the nature of their problem if known. \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature (if minor, parent must sign) / Date**

\_\_\_\_\_  
**Physician Signature / Date**