Nutrition Patient Questionnaire

Date:_____ Patient #_____

Name_____ __ Date of Birth_____

Address_____ City/State_____

E-Mail_____ Zip Code_____

By documenting your email address on this page, you are agreeing that health information for yourself can be freely shared via email between yourself and Restoration Chiropractic. While usually considered safe, email is not the most secure method of sharing personal information.

Telephone: Home_____ Cell:_____

Place of Employment_____ Occupation_____

Married____ Single____ Divorced____ Widow(er)____ # of Children____

Spouse's Name_____ Place of Employment_____

Emergency Contact:

Name_____ Phone_____ Relationship_____

How did you hear about our office?_____

You are responsible for payment in full at the time of service. By signing below you are stating that you clearly understand that all services rendered at Restoration Chiropractic are your responsibility and payment is expected at the time of service. We are providing services outside of the insurance network guidelines; these services are not covered and the patient is responsible for these. Insurance will not and cannot be filed for these particular services provided.

NUTRITIONAL INFORMED CONSENT

According to the food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above.

Signature_____ Date_____

Restoration Chiropractic: Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your application for care, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctor at this office practices chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

- PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

- YOUR CARE – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at ScoliosisKC is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor's use a myriad of techniques to accomplish this goal, including but not limited to the latest techniques for spinal correction. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

- FIRST THINGS FIRST – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered to confirm the true nature of your condition and exact location of subluxations. You will be notified in advance if any further fees will be applicable. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

I hereby acknowledge that I have read and understand the practices "Office Policies'. This signature page will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all of my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient's Printed Name	Patient Signature	DOB ___/___/___	Date

Restoration Chiropractic: Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as directed by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. Once you have read this notice, please sign.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care
2. Inadvertent disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders- we may call your home and leave messages regarding a missed appointment or notify you of changes in practice hours or upcoming events.
11. Change of ownership-in the event this practice is sold, the new owners would have access to your patient information.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of this Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To request amendments to information. However, like restrictions, we are not required to agree to them.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like a copy on a disc, there will be a fee, which is your responsibility.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Mary at 816-425-5578. If she is unavailable, you may make an appointment with our office assistant to see her with 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have read and understand Restoration Chiropractic & ScoliosisKC's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Printed Name	Patient Signature	___/___/___ DOB	Date